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No. 14-181

In The Supreme Court of the United States

ALFRED GOBEILLE, in his official capacity as chair of the Vermont Green Mountain Care Board,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

JOINT APPENDIX

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Petition For Certiorari Filed August 13, 2014
Certiorari Granted June 29, 2015

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U.S. District Court
District of Vermont (Burlington)
CIVIL DOCKET FOR CASE #: 2:11-cv-00204-wks

Liberty Mutual Insurance Company v. Kimbell
Assigned to: Judge William K. Sessions III
Cause: 29:1001 E.R.I.S.A.: Employee Retirement

Date Filed: 08/12/2011
Jury Demand: None
Nature of Suit: 791 Labor: E.R.I.S.A.
Jurisdiction: Federal Question

Date Filed	#	Docket Text
08/12/2011	1	VERIFIED COMPLAINT for Declaratory Judgment and Other Relief against Stephen W. Kimbell filed by Liberty Mutual Insurance Company. (Attachments: # 1 Exhibit A, # 2 Civil Cover Sheet)(law) (Entered: 08/12/2011)
08/12/2011	2	MOTION for Preliminary Injunction filed by Liberty Mutual Insurance Company (Attachments: # 1 Memorandum in Support)(law) (Entered: 08/12/2011)
08/25/2011	11	MOTION to Withdraw 2 MOTION for Preliminary Injunction filed by Liberty Mutual Insurance Company.(Behm, R.) (Entered: 08/25/2011)
08/25/2011	12	ORDER granting 11 Motion to Withdraw 2 Motion for Preliminary Injunction. Signed by Judge William K. Sessions III on 08/25/11. (This is

		a text only Order.) (eae) (Entered: 08/25/2011)
09/15/2011	15	MOTION to Dismiss filed by Stephen W. Kimbell.(Cassetty, David) (Entered: 09/15/2011)
11/01/2011	22	RESPONSE in Opposition re 15 MOTION to Dismiss filed by Liberty Mutual Insurance Company. (Attachments: # 1 Declaration of Mary Connolly, # 2 Exhibit A, # 3 Exhibit B, # 4 Exhibit C, # 5 Exhibit D)(Behm, R.) (Entered: 11/01/2011)
11/22/2011	25	REPLY in Support of 15 MOTION to Dismiss filed by Stephen W. Kimbell. (Cassetty, David) Text clarified on 11/23/2011 (jlh). (Entered: 11/22/2011)
11/28/2011	26	MOTION for Leave to File *a Sur-Reply in Opposition* as to 15 MOTION to Dismiss filed by Liberty Mutual Insurance Company. (Attachments: # 1 Attachment 1)(Behm, R.) Attachment description clarified on 11/28/2011 (law). (Entered: 11/28/2011)
11/29/2011	28	ORDER granting as unopposed 26 Motion for Leave to File a Sur-Reply in Opposition as to 15 Motion to Dismiss. Signed by Judge William K. Sessions III on 11/29/11. (This is a text only Order.) (eae) (Entered: 11/29/2011)

06/25/2012	35	MOTION for Summary Judgment filed by Liberty Mutual Insurance Company. (Attachments: #1 Memorandum in Support, # 2 Statement of Undisputed Material Facts)(Behm, R.) (Entered: 06/25/2012)
06/25/2012	36	DECLARATION of Mary Connolly re: 35 MOTION for Summary Judgment by Liberty Mutual Insurance Company.. (Behm, R.) (Entered: 06/25/2012)
06/25/2012	37	DECLARATION of John A. Litwinski re: 35 MOTION for Summary Judgment by Liberty Mutual Insurance Company.. (Attachments: # 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C – part 1, # 4 Exhibit C – part 2, # 5 Exhibit D, # 6 Exhibit E, # 7 Exhibit F, # 8 Exhibit G, # 9 Exhibit H, # 10 Exhibit I, # 11 Exhibit J, # 12 Exhibit K)(Behm, R.) (Entered: 06/25/2012)
08/17/2012	48	RESPONSE in Opposition to 35 MOTION for Summary Judgment filed by Stephen W. Kimbell. (Attachments: # 1 Affidavit of Dian Kahn, # 2 Statement of Disputed Material Facts)(Cassetty, David) (Entered: 08/17/2012)
09/05/2012	49	NOTICE *of Supplemental Authority* by Stephen W. Kimbell (Attachments: # 1 Self-Insurance Institute of America, Inc. v. Snyder, case no. 11-15602, 2012WL3779172)(Cassetty, David)

Attachment description clarified on 9/5/2012 (law). (Entered: 09/05/2012)

09/06/2012 51 REPLY to Response to 35 MOTION for Summary Judgment filed by Liberty Mutual Insurance Company. (Behm, R.) Text clarified on 9/6/2012 (law). (Entered: 09/06/2012)

09/10/2012 52 MOTION for Leave to File *a Response* as to 49 Notice *of Supplemental Authority* filed by Liberty Mutual Insurance Company. (Attachments: # 1 Exhibit A)(Behm, R.) Text clarified on 9/10/2012 (law). (Entered: 09/10/2012)

09/19/2012 56 MINUTE ENTRY for proceedings held before Judge William K. Sessions III: Motion Hearing held on 9/19/2012 re 35 MOTION for Summary Judgment, 15 MOTION to Dismiss. Miller Baker, Esq., Andrew Liazos, Esq. &Jeffrey Behm, Esq. present for pltf; David Cassetty, Esq. &Clifford Peterson, Esq. present for dft. Court makes inquiries. Statements by counsel. Motions Taken Under Advisement: 35 MOTION for Summary Judgment, 15 MOTION to Dismiss. (Court Reporter: Nichols Pierce) (jam) (Entered: 09/19/2012)

10/02/2012 57 TRANSCRIPT of Motion to Dismiss and Motion for Summary Judgment Hearing held on 9/19/2012 before Judge Sessions. Court Reporter/

Transcriber Anne Nichols Pierce, Telephone number 802-860-2227. Transcript may be viewed at the court public terminal or purchased through the Court Reporter/ Transcriber before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER Redaction Request due 10/25/2012. Redacted Transcript Deadline set for 11/2/2012. Release of Transcript Restriction set for 12/31/2012. (jam) (Entered: 10/02/2012)

10/05/2012 58 POST-HEARING MEMORANDUM re: 35 MOTION for Summary Judgment by Liberty Mutual Insurance Company. (Attachments: # 1 Declaration of John A. Litwinski, # 3 Exhibit A, # 4 Exhibit B, # 5 Exhibit C, # 2 Declaration of Mary Connolly)(Behm, R.) (Attachment 1 broken out on 10/7/2012) (law). (Entered: 10/05/2012)

10/07/2012 59 NOTICE OF DOCKET ENTRY CORRECTION re: 58 Post-Hearing Memorandum filed by Liberty Mutual Insurance Company. The Declaration of John A. Litwinski document image contained that of Exhibits A, B and C. The images have been broken apart and replaced on the docket. The corrected images are also attached to this entry. (Attachments:

		# 1 Exhibit A, # 2 Exhibit B, # 3 Exhibit C) (law) (Entered: 10/07/2012)
10/10/2012	60	RESPONSE re 58 Post-Hearing Memorandum re: 35 MOTION for Summary Judgment by Stephen W. Kimbell. (Cassetty, David) Link added on 10/10/2012 (jlh). (Entered: 10/10/2012)
11/09/2012	61	OPINION AND ORDER denying 35 Motion for Summary Judgment; granting 52 Motion for Leave to Respond to dft's Notice of Supplemental Authority; granting in part and denying in part 15 Motion to Dismiss, granted with respect to ERISA preemption and denied with respect to standing. Signed by Judge William K. Sessions III on 11/9/2012. (jam) (Entered: 11/09/2012)
11/12/2012	62	JUDGMENT granting 15 motion to dismiss with respect to preemption. Signed by Deputy Clerk on 11/12/2012. (Attachments: # 1 Notice to Litigants (appeal period expires (12/13/2012))(law) (Entered: 11/12/2012)
12/10/2012	63	NOTICE OF APPEAL as to 61 Opinion and Order; 62 Judgment by Liberty Mutual Insurance Company. Filing fee $ 455. Paid R# 4682008141. (gmg) (Entered: 12/10/2012)

12/19/2012	64	TRANSMITTED Index on Appeal Circuit No. 12-4881 re: 63 Notice of Appeal. (gmg) (Entered: 12/19/2012)
05/23/2014	67	MANDATE of USCA Circuit No. 12-4881 as to 63 Notice of Appeal filed by Liberty Mutual Insurance Company. It is ORDERED that the 62 judgment of the district court is REMANDED with instructions to enter judgment for Liberty Mutual in accordance with the opinion of this court. (Attachments: # 1 Opinion)(gmg) (Entered: 05/23/2014)

General Docket
Court of Appeals, Second Circuit

Court of Appeals Docket #: 12-4881 **Docketed:** 12/13/2012
Termed: 02/04/2014
Nature of Suit: 3791 LABOR LAWS-Retirement Act 1974
Liberty Mutual Insurance Compa v. Kimbell
Appeal From: DISTRICT OF VERMONT (BURLINGTON)
Fee Status: Paid

12/13/2012	1	NOTICE OF CIVIL APPEAL, with district court docket, on behalf of Appellant Liberty Mutual Insurance Company, FILED. [794017] [12-4881] [Entered: 12/13/2012 09:08 AM]
12/27/2012	34	ELECTRONIC INDEX, in lieu of record, FILED.[804980] [12-4881] [Entered: 01/02/2013 11:09 AM]
03/29/2013	50	BRIEF & SPECIAL APPENDIX, on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 03/29/2013 by CM/ECF. [892448] [12-4881] [Entered: 03/29/2013 02:47 PM]
03/29/2013	51	JOINT APPENDIX, volume 1 of 2, (pp. 1-286), on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 03/29/2013 by CM/ECF.[892486] [12-4881] [Entered: 03/29/2013 03:04 PM]

03/29/2013	52	JOINT APPENDIX, volume 2 of 2, (pp. 287-382), on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 03/29/2013 by CM/ECF.[892491] [12-4881] [Entered: 03/29/2013 03:07 PM]
04/09/2013	64	AMICUS BRIEF, on behalf of Amicus Curiae Chamber of Commerce of the United States of America, FILED. Service date 04/09/2013 by CM/ECF. [901090] [12-4881] – [Edited 04/09/2013 by JW] [Entered: 04/09/2013 11:24 AM]
06/19/2013	71	Stephen Kimbell, replaced by Susan L. Donegan, SUBSTITUTED.[973819] [12-4881] [Entered: 06/24/2013 04:35 PM]
06/24/2013	72	AMENDED CAPTION PAGE, removing Stephen Kimbell and substituting in Susan Donegan and her title, SENT.[973826] [12-4881] [Entered: 06/24/2013 04:36 PM]
06/27/2013	73	BRIEF, on behalf of Appellee Susan L. Donegan, FILED. Service date 06/27/2013 by CM/ECF. [977273] [12-4881] [Entered: 06/27/2013 02:28 PM]
07/10/2013	81	AMICUS BRIEF, on behalf of Amicus Curiae Seth D. Harris, FILED. Service date 07/03/2013 by CM/ECF. [985743] [12-4881] – [Edited 07/10/2013 by JW] [Entered: 07/10/2013 12:07 PM]

07/17/2013	88	REPLY BRIEF, on behalf of Appellant Liberty Mutual Insurance Company, FILED. Service date 07/17/2013 by CM/ECF. [993230] [12-4881] [Entered: 07/17/2013 05:48 PM]
11/18/2013	110	CASE, before ALK, DJ, CJS, C.JJ., HEARD.[1094990] [12-4881] [Entered: 11/18/2013 12:13 PM]
02/04/2014	118	OPINION, the district court judgment is reversed and remanded with instructions to enter judgment for Liberty Mutual, by ALK, DJ, CJS, FILED.[1148788] [12-4881] [Entered: 02/04/2014 09:19 AM]
02/04/2014	119	OPINION, Concurring & Dissenting, by Judge Straub, FILED.[1148794] [12-4881] [Entered: 02/04/2014 09:22 AM]
02/04/2014	121	CERTIFIED OPINION, dated 02/04/2014, to DISTRICT OF VERMONT (BURLINGTON), ISSUED. [1148804] [12-4881] [Entered: 02/04/2014 09:26 AM]
02/04/2014	125	JUDGMENT, FILED.[1149244] [12-4881] [Entered: 02/04/2014 12:39 PM]
02/18/2014	126	PETITION FOR REHEARING/ REHEARING EN BANC, on behalf of Appellee Susan L. Donegan, FILED. Service date 02/18/2014 by US mail, CM/ECF.[1158736] [12-4881] [Entered: 02/18/2014 03:55 PM]

05/16/2014 130 ORDER, petition for rehearing en banc denied, FILED.[1226687] [12-4881] [Entered: 05/16/2014 01:47 PM]

05/23/2014 131 JUDGMENT MANDATE, ISSUED. [1232584] [12-4881] [Entered: 05/23/2014 02:44 PM]

08/15/2014 132 U.S. SUPREME COURT NOTICE of writ of certiorari filing, dated 08/15/2014, U.S. Supreme Court docket # 14-181, RECEIVED. [1298748] [12-4881] [Entered: 08/19/2014 01:26 PM]

06/29/2015 136 U.S. SUPREME COURT NOTICE, dated 06/29/2015, U.S. Supreme Court docket # 14-181, stating the petition for writ of certiorari is granted, RECEIVED.[1543469] [12-4881] [Entered: 06/30/2015 11:42 AM]

UNITED STATES DISTRICT COURT
DISTRICT OF VERMONT

Liberty Mutual Insurance Company Plaintiff, v. Stephen W. Kimbell, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration, Defendant.	)	2:11-cv-204

VERIFIED COMPLAINT FOR DECLARATORY JUDGMENT AND OTHER RELIEF

Plaintiff Liberty Mutual Insurance Company ("Liberty Mutual"), through its undersigned attorneys, for its verified complaint against defendant Stephen W. Kimbell ("Defendant") in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration ("BISHCA"), states as follows:

JURISDICTION AND VENUE

1. This is an action pursuant to the Declaratory Judgment Act, 28 U.S.C. § 2201, *et seq.* and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* This case involves

an actual controversy between the parties as to whether ERISA preempts a state statute and regulation requiring the disclosure to BISHCA of confidential health care information and records of medical treatment provided to private individuals in Vermont.

2. This Court has subject matter jurisdiction under both ERISA Section 502(e)(1), which provides the Court with exclusive jurisdiction to hear suits under Section 502(a)(3), and 28 U.S.C. § 1331.

3. Venue in this Court is proper under Section 502(e)(2) of ERISA because this is the District where the threatened violation of ERISA will take place and because the Defendant resides or may be found in this District.

PARTIES

4. Plaintiff Liberty Mutual is an insurance company organized under the laws of the Commonwealth of Massachusetts. Liberty Mutual is a wholly owned subsidiary of Liberty Mutual Group Inc. Liberty Mutual's principal offices are located at 175 Berkeley Street, Boston, Massachusetts 02116. Liberty Mutual has employees and offices in Vermont and conducts business in Vermont.

5. Defendant Stephen W. Kimbell is Commissioner of BISHCA for the State of Vermont, and is named as Defendant in that capacity. Pursuant to Vermont statutory authority, BISHCA has promulgated Regulation H-2008-01 ("Regulation"), which

generally requires that private health care data and records of individuals' medical treatment be provided to BISHCA. The Regulation is intended to implement the creation of a "unified health care data base" pursuant to 18 V.S.A. § 9410. The Regulation states that it was "issued pursuant to the authority vested in the Commissioner of" BISHCA.

BACKGROUND AND FACTS

A. Liberty Mutual's ERISA-Governed Employee Welfare Benefit Plan and Its Third Party Administrator

6. Approximately 54 years ago, Liberty Mutual established the Liberty Mutual Medical Plan (the "Plan") for the benefit of its employees. The Plan provides a broad range of medical care benefits to Liberty Mutual's employees and their beneficiaries. As of June 30, 2011, the Plan provides medical benefits to 84,711 persons throughout the United States, including 32,933 employees of Liberty Mutual Group Inc. and its subsidiaries, as well as employees' families and company retirees. Of these people, 137 are in Vermont, including all company employees in Vermont and their families. Liberty Mutual does not offer the right to participate in the Plan to a Vermont resident unless such individual is an employee of Liberty Mutual Group Inc., or one of its participating subsidiaries, a qualifying family member of such an employee, or an eligible company retiree.

7. The Plan is an employee welfare benefit plan governed by ERISA. *See* ERISA Section 3(1), codified at 29 U.S.C. § 1002(1). Liberty Mutual was at all times relevant hereto a "named fiduciary" and "plan administrator" of the Plan within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002. Liberty Mutual Group Inc. is the "Plan Sponsor" within the meaning of Section 3 of ERISA, 29 U.S.C. § 1002.

8. The Plan provides medical benefits that are self-insured by Liberty Mutual Group Inc., meaning that Liberty Mutual Group Inc. pays all benefits provided under the Plan from its own general assets. Blue Cross Blue Shield of Massachusetts, Inc. ("BCBSMA" or the "TPA") is the Plan's third party administrator, and it administers the medical claims and associated confidential medical records of Plan participants and beneficiaries. BCBSMA is also in possession of, and on an ongoing basis continues to receive, confidential and private medical data and records involving Plan participants and beneficiaries.

B. The Pertinent ERISA Provisions

9. ERISA is a comprehensive federal statute that regulates private employee benefit plans in order to provide protection to plan participants and beneficiaries. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 209 (2002); http://www.dol.gov/dol/topic/health-plans/erisa.htm (last visited August 11, 2011). One of the primary purposes of ERISA is to provide for the "uniform national treatment" of

employee benefit plans. *Arnold v. Lucks*, 392 F.3d 512, 519 (2d Cir. 2004) (citing *Yates Profit Sharing Plan v. Hendon*, 124 S. Ct. 1330, 1331 (2004)).

10. "ERISA expressly preempts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered by the statute." *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18, 22 (2d Cir. 1996) (citations omitted). "The express preemption provisions of ERISA are deliberately expansive. . . . [and] are among the broadest that can be found in the law." *Id.*

11. Section 404 of ERISA governs how fiduciaries of ERISA-governed plans are to behave. *See generally* ERISA § 504, codified at 29 U.S.C. § 1104. Section 404(a)(1)(A) of ERISA provides that a plan fiduciary, like Liberty Mutual, "shall discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and . . . *for the exclusive purpose* of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan." ERISA § 404(a)(1)(A), codified as 29 U.S.C. § 1104(a)(1)(A) (emphasis added). Accordingly, ERISA forbids Liberty Mutual, a Plan fiduciary, from using the Plan for any purpose other than to provide benefits to Plan participants and beneficiaries.

12. In addition, ERISA provides "detailed reporting and disclosure requirements." *Massachusetts v. Morash*, 490 U.S. 107, 118 (1999); *see* 29 U.S.C. §§ 1023-1030. Part 1 of Subtitle B of ERISA

sets forth the reporting and disclosure duties of an administrator of a large employee welfare benefit plan such as the Plan. These requirements include publishing an annual report that is filed with the Secretary of Labor. *See* Section 103 of ERISA The annual report sets forth identifying information regarding the plan, the number of participants, the plan's funding arrangement and the plan's benefit arrangement. The annual report does not require any disclosure of the confidential, individualized health care and medical claims information sought by BISHCA. *See* ERISA Section 106, codified at 29 U.S.C. § 1026. Section 502(c)(2) of ERISA and the regulations thereunder set forth the penalties for failure to comply with ERISA's annual reporting requirements.

13. ERISA makes clear that the United States Department of Labor is the entity Congress contemplated and authorized to collect and analyze data regarding ERISA health plans. Section 513 of ERISA expressly gives the Secretary of Labor "authori[ty] to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to . . . welfare plans" such as the Plan. 29 U.S.C. § 1143(a). ERISA does not provide the States with authority to collect data from ERISA plans, but rather vests that authority in the Department of Labor.

14. Despite its considerable breadth, ERISA preemption does not extend to state laws that regulate only insurance, banking, or securities. *See* ERISA

§ 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A). This exception to the general rule of ERISA preemption is known as the "Savings Clause." Under the Savings Clause, states are generally permitted to enact laws regulating only insurance. *See id.*

15. The "Deemer Clause" was also included in Section 514 of ERISA to ensure that the Savings Clause was not used as an end-run around ERISA's sweeping preemption provision. *See* ERISA § 514(b)(2)(B), codified at 29 U.S.C. § 1144(b)(2)(B). The Deemer Clause provides that a self-funded plan shall not "be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any state law purporting to regulate" insurance businesses. *Id.* The Deemer Clause makes clear that a state law will not avoid ERISA preemption by merely deeming an employee benefit plan to be an insurer.

16. Nothing in ERISA permits a State to deem a self-insured employee welfare benefit plan or those providing administrative services to such a plan to be an insurance company so that it can require reporting of confidential, personal medical information to create its own proprietary health care database.

C. BISHCA and the Regulation

17. BISHCA is a Vermont state agency which, according to its website, "provid[es] a single point of access for consumer complaint resolution, enforcement authority, and legislative contact on issues

affecting financial and health care services in Vermont." http://www.bishca.state.vt.us/ (last visited Aug. 7, 2011). The Division of Health Care Administration, one of BISHCA's divisions, "regulates and monitors key sectors of Vermont's health care system to ensure that all Vermonters have access to health care that is affordable and meets accepted standards for quality." http://www.bishca.state.vt.us/health-care/health-care-administration (last visited Aug. 9, 2011). The Defendant is the Commissioner of BISHCA.

18. The state of Vermont has enacted 18 V.S.A. § 9410 (the "Statute") in its effort to regulate heath care administration. The Statute calls for BISHCA to create a "unified health care database," so that the Commissioner of BISHCA can carry out certain duties. *See* 18 V.S.A. § 9410(a)(1). These duties include: 1) determining the capacity and distribution of existing resources; 2) identifying health care needs and informing health care policy; 3) evaluating the effectiveness of intervention programs on improving patient outcomes; 4) comparing costs between various treatment settings and approaches; 5) providing information to consumers and purchasers of health care; and 6) improving the quality and affordability of patient health care and health care coverage. *See* 18 V.S.A. § 9410(a)(1)(A)-(F). These goals have nothing to do with regulating insurance but are, instead, directly aligned with the stated mission of BISHCA's Division of Health Care Administration. BISHCA is also granted enforcement responsibilities under the Statute.

19. Pursuant to the Statute, BISHCA promulgated Regulation H-2008-01 (the "Regulation") to implement the creation of a "unified health care data base." The Regulation states that "[t]he purpose of this rule is to set forth the requirements for the *submission of health care claims data, member eligibility data, and other information relating to health care* provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, *third party administrators*, pharmacy benefit managers and others to [BISHCA] . . . and conditions for the use and dissemination of such claims data . . . consistent with the purposes of 18 V.S.A. § 9410." *See* Regulation Section 1 (emphasis added).

20. In furtherance of this purpose, the Regulation requires "Health Insurers" to "regularly submit *medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care* provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to [BISHCA]." *See* Regulation Section 4(A) (emphasis added).

21. The Regulation broadly defines "Health Insurer" to include any "third party administrator . . . and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by

Vermont health care providers and facilities. The term may also include . . . any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities." *See* Regulation § 3(X). By its terms, the definition includes plan administrators, like Liberty Mutual, and third party administrators, like BCBSMA.

22. Accordingly, the Regulation requires Liberty Mutual and BCBSMA to annually report the Plan's private health care data and records of individuals' medical treatment to BISHCA.

D. The Issuance of the BISHCA Subpoena

23. BISHCA has repeatedly attempted to apply the Statute and Regulation to Liberty Mutual's ERISA-governed Plan. BISHCA has recently made several demands that Liberty Mutual and BCBSMA report the Plan's medical claims data. The information sought includes Plan participants' and beneficiaries' name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, the co-payment or coinsurance amount, and drug code, among other information. *See* Regulation, at Appendix C-1.

24. In late May 2011, BCBSMA informed Liberty Mutual that BISHCA was being "very aggressive" in its efforts to enforce the claims data reporting Regulation and was pressuring BCBSMA to report the claims data for Liberty' Mutual's Plan.

25. Both Liberty Mutual and BCBSMA have made numerous attempts to persuade BISHCA to abandon its efforts to apply the Regulation to the Plan. On June 6, 2011, Mary Connolly, the Vice President of Benefits at Liberty Mutual, and Liberty Mutual's Counsel Nancy L. Keating, spoke with Clifford Peterson, General Counsel for the Health Care Division of BISHCA, regarding the Vermont reporting rules and the issue of ERISA preemption. During that discussion, Mr. Peterson indicated that BISHCA would likely take enforcement action against BCBSMA if it failed to report the individual medical records and data of Plan participants and beneficiaries in the precise manner demanded by BISHCA. Liberty Mutual requested that BISHCA reconsider its insistence that the TPA report confidential health care information and participant medical records.

26. Subsequently, Jack Myers of BCBSMA communicated to Ms. Connolly that BISCHA "was about to take imminent action against" BCBSMA if it failed to submit the specific information, records and data demanded by BISCHA regarding Plan participants and beneficiaries.

27. On July 29, 2011, Ms. Connolly and Ms. Keating again spoke to BISHCA General Counsel Clifford Peterson and informed him that Liberty Mutual would continue to instruct BCBSMA not to report the claims data to BISHCA as it was inconsistent with the requirements of ERISA, and BISHCA had no right to compel a self-insured medical plan to

disclose confidential health care information so BISHCA could create a health care database, because the Regulation was preempted by ERISA. Mr. Peterson responded that ERISA did not preempt the Vermont reporting rules.

28. Subsequently, on August 5, 2011, the Defendant served a subpoena on BCBSMA and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.[1] (the "Subpoena"). *See* Exhibit A.

29. The Subpoena demands that the TPA produce "Eligibility files for the following months of incurred service for 2011: April, May, June"; "Medical claim files for the following months of incurred service for 2011: January, April, May, June"; and "Pharmacy claim files for the following months of incurred service for 2011: April, May, June." The data demanded in the Subpoena includes personal identifying information regarding individual Plan participants' and beneficiaries' medical treatment, including Plan member name, gender, date of birth, city zip code, social security number, diagnosis and procedure code, type of bill paid, amount charged, co-payment or coinsurance amount, and drug code, among other items of information.

30. The Subpoena states that "*the files which precede the June filing period are overdue to the*

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[1] Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. does not provide services to the Plan, nor has the Plan provided medical records or data to that entity.

Department, and the June filings are due by July 31, 2011." (emphasis added).

31. The Subpoena further states that "[p]ursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records . . . ***may be assessed a penalty by the Commissioner of not more than $2,000.00 for each day*** of noncompliance and proceeded against as provided in the Administrative Procedure act, and that person's ***authority to do business may be suspended*** for not more than six months." (emphasis added).

E. <u>The Controversy Between the Parties</u>

32. Liberty Mutual, as the Plan administrator, has repeatedly resisted BISHCA's attempt to require the reporting or other disclosure of the confidential information, records, and data of Plan participants and beneficiaries, for three primary reasons.

33. First, the Statute and Regulation are preempted by ERISA. Specifically, the Statute and Regulation impose a new reporting regime on self-funded medical plans that requires reporting and disclosure different in kind and in scope from what is imposed under ERISA. As such, the Statute and Regulation are an attempt to intrude upon the uniform and exclusive regulation of employee benefit plans that Congress provided under ERISA. BISHCA has attempted to avoid ERISA's preemptive effect by defining "Health Insurers" to include plan administrators and third party administrators. However, this

is nothing more than a legal fiction designed to allow BISHCA to improperly seek the confidential health care information, private medical records, and data of the Plan's participants and beneficiaries. Significantly, ERISA's Deemer Clause expressly rejects states' attempts to classify employee benefit plans as insurance companies in order to regulate them. BISHCA's attempt to treat Liberty Mutual and BCBSMA as "health insurers" is further belied by the fact that no Vermont resident without ties to Liberty Mutual Group Inc. and its subsidiaries can purchase insurance under the Plan.

34. Second, providing the Plan's claims data to BISHCA under the Statute and Regulation could constitute a violation of Liberty Mutual's ERISA fiduciary duties. The duties outlined in Section 404 of ERISA compel Liberty Mutual to safeguard against the type of detailed and intrusive reporting regime being imposed by BISHCA, particularly because BISHCA may release claims data to various third parties who request such data. *See* Regulation Section 9. Quite simply, the Plan may not be administered at the expense of the Plan and its participants in order to develop a health care database so that the State of Vermont can best determine how health care should be provided to residents.

35. Third, the Plan owns the claims data that BISHCA seeks, and Liberty Mutual Group Inc. and its subsidiaries, as a national employer, has designed the Plan to meet its own competitive needs in the marketplace. Accordingly, BISHCA is not entitled to

information related to the Plan design, including which claims the Plan does and does not cover or what a member's required coinsurance or copayments may be under the Plan, nor is it entitled to information relating to a participant's confidential medical claims information. BISHCA is similarly not entitled to compel the Plan's service providers (like BCBSMA) to report such information, irrespective of whether that individual is or is not a Vermont resident, since the service providers have no right to release the data to BISHCA without Liberty Mutual's consent.

COUNT I
ERISA Section 502(a)(3)

36. Plaintiff re-alleges and incorporates by reference all preceding allegations in this Complaint as though fully set forth in this Count I.

37. Section 502(a)(3) of ERISA provides that "[a] civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

38. There exists an actual controversy between Liberty Mutual and Defendant, which controversy can be resolved by a judgment of this Court.

39. Defendant subpoenaed the TPA demanding it turn over confidential health care information and

private medical records and data of Liberty Mutual's Plan participants and beneficiaries, and threatening the TPA with substantial fines and loss of its ability to do business in Vermont if it does not comply with the subpoena. The TPA has indicated that absent preliminary injunctive relief from this Court, the TPA will be forced to, and will, comply with the Subpoena and turn over the medical records and data being demanded.

40. Liberty Mutual, as Plan administrator and named fiduciary, therefore sues under Section 502(a)(3) of ERISA seeking a declaratory judgment and to enjoin Defendant's attempt to force the TPA to produce the subpoenaed information because Defendant's actions, and the Regulation and 18 V.S.A. § 9410, each violate and are preempted by ERISA.

41. Plan participants and beneficiaries who are Vermont residents, as well as the Plan and its fiduciaries, will suffer irreparable harm if enforcement of the Subpoena is not preliminarily and permanently enjoined.

WHEREFORE, Liberty Mutual respectfully requests that this Court:

A. Declare that BISHCA's Regulation H-2008-01 and the Vermont health care database statute set forth in 18 V.S.A. § 9410 are preempted by ERISA to the extent they require the reporting, production, or disclosure of any confidential health care information or medical records or data relating to the Plan or its participants and beneficiaries;

B. Preliminarily and permanently enjoin the Defendant from attempting to obtain, from the TPA or any other source, any medical records or data relating to the Plan or its participants and beneficiaries;

C. Award Liberty Mutual its reasonable attorney's fees and costs incurred in this action pursuant to ERISA Section 502(g); and

D. Grant such further equitable relief as may be deemed appropriate.

Dated: August 12th, 2011

Respectfully submitted,

/s/ R. Jeffrey Behm

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VERIFICATION

I, Mary Connolly, have reviewed the allegations made in this Verified Complaint and swear and affirm under penalties of perjury of the laws of the United States of America that they are true and correct to the best of my knowledge and belief.

/s/ Mary Connolly
Mary Connolly
Vice President & Manager of Benefits
Liberty Mutual Insurance Company

Subscribed and sworn to
before me this 12 day of
August, 2011

/s/ Jeanne Morse
Notary Public

[SEAL]

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

TO: Blue Shield of Massachusetts HMO Blue, Inc. AND Blue Cross and Blue Shield of Massachusetts, Inc.	))))	Docket No. 11-035-H

SUBPOENA

Pursuant to the authority contained in 8 V.S.A. §13, YOU ARE HEREBY DIRECTED TO PRODUCE to *Onpoint Health Data*, duly-appointed contractor of the Department of Banking, Insurance, Securities and Health Care Administration, located at 16 Association Drive, Manchester, Maine, 04351, THE INFORMATION, DATA, AND DOCUMENTS SPECIFIED IN THE ATTACHED EXHIBIT "A" on or before *August 10, 2011* and pursuant to the instructions in Exhibit "A." The data should be submitted in the same manner as previous submissions.

The terms "information, data, and documents" include, but are not limited to, all records and other tangible forms of expression, drafts or finished versions, originals, copies of annotated copies, however produced or stored (manually, mechanically, electronically or otherwise), including but not limited to books, papers, files, notes, correspondence, memoranda, ledger sheets, reports, telegrams, telexes, facsimiles, telephone logs, contracts, agreements, calendars or date books, phone logs, bank statements, worksheets, computer

files including electronic mail, software disk packs and other electronic media and the documents generated therefrom, microfilm, microfiche, and storage devices.

Pursuant to 8 V.S.A. § 13(b), a person who fails or refuses to produce papers or records for examination before the Commissioner, upon properly being ordered to do so, may be assessed an administrative penalty by the Commissioner of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and that person's authority to do business may be suspended for not more than six months.

Dated at Montpelier, Vermont this 2nd day of August, 2011.

By: /s/ S. W. Kimball
STEPHEN W. KIMBALL,
COMMISSIONER
Vermont Department
of Banking, Insurance,
Securities and Health
Care Administration

Instructions

The following files for Vermont enrollees ("the files") are due to the Vermont Department of Banking, Insurance, Securities and Health Care Administration ("the Department") to meet ongoing reporting requirements of the State's Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) as specified in State Reg. H-2008-01. The files which precede the June filing period are overdue to the Department, and the June filings are due by July 31, 2011 and must be electronically filed with Onpoint Health Data, the State of Vermont's designated contractor.

All files must meet the same filing requirements and be electronically filed in the same manner as the historic production files that have already been submitted to Onpoint Health Data by Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. for preceding filing periods.

Following production of these files, Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. are to resume timely submissions of monthly production files.

Data To Be Produced

The files are:

1. Blue Cross Blue Shield of Massachusetts, Inc.

    - Eligibility files for the following months of incurred services for 2011: April, May, June
    - Medical claims files for the following months of incurred services for 2011: January, April, May, June
    - Pharmacy claims files for the following months of incurred services for 2011: April, May, June

2. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.

    - Eligibility files for the following months of incurred services for 2011: April, May, June
    - Medical claims files for the following months of incurred services for 2011: January, March, April, May, June
    - Pharmacy claims files for the following months of incurred services for 2011: April, May, June

LIBERTY MUTUAL MEDICAL PLAN

Amended and Restated as of January 1, 2001

Liberty Mutual Insurance Company

LIBERTY MUTUAL MEDICAL PLAN

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[1] LIBERTY MUTUAL MEDICAL PLAN

ARTICLE I. PREAMBLE

Section 1.1 The Plan.

Liberty Mutual Insurance Company (the "Company") established the Liberty Mutual Medical Plan (the "Plan") effective July 1, 1957. The Plan is hereby amended and restated as of January 1, 2001.

Section 1.2 Purpose and Intent.

The purpose of the Plan is to provide to Participants medical benefits.

The Plan is intended to meet all applicable requirements of the Internal Revenue Code ("Code") and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as well as rulings and regulations issued or promulgated thereunder. Nothing in the Plan shall be construed as requiring compliance with Code or ERISA provisions that do not otherwise apply.

Section 1.3 Definitions.

The following terms, where capitalized, shall have the meanings set forth below unless otherwise specified herein:

(a) "Code" means the Internal Revenue Code of 1986, as amended.

(b) "Company" means Liberty Mutual Insurance Company, a mutual insurance company organized under the laws of Massachusetts. In the event of the reorganization, merger or similar transaction affecting the Company, any successor entity may adopt the Plan for the benefit of employees of such successor, in which event, the Plan shall continue without any gap or lapse in coverage.

(c) "Dependent" means (a) an Employee's spouse; and (b) an Employee's unmarried child (including any stepchild, foster child,

legally adopted child or a child for whom a court order of custody or guardianship has been obtained) under age 19. If an unmarried child age 19 or over is a full-time student in a school, college or university, he is a dependent until he reaches age 25. "Dependent" does not include a person who is covered under this Plan as an Employee or a legally divorced spouse (except divorced spouses of Massachusetts employees covered pursuant to Section 110 I of Chapter 175 of the Massachusetts General Laws, prior to 1/1/91). Coverage for a dependent child who reaches age 19 will be continued under this Plan if the dependent child is unable to earn his own living because of a physical handicap, mental illness or developmental disability.

[2] (d) "Effective Date" of the Plan as amended and restated is January 1, 2001.

(e) "Employee" means any individual employed on the U.S. payroll by the Company, or by subsidiaries of the Company that participate in the Plan, on a regular full time basis, or regular part-time basis (if scheduled and regularly working 20 hours or more per week). Individuals classified as independent contractors or leased employees are not eligible for coverage, even if they are later reclassified as common law employees for tax purposes.

(f) "Employer" means the Company, and subsidiaries of the Company that participate in the Plan. The Company shall have the right to

terminate any Employer's adoption of the Plan at any time. If an Employer merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Employees covered by the Plan immediately before such merger or consolidation, be the Employer as defined hereunder, unless the Company specifies to the contrary. In case of any other merger or consolidation, the successor shall not be the Employer except to the extent that it acts to adopt the Plan. Each Employer is identified in Appendix A. The Company shall amend Appendix A as needed, to reflect an Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan.

(g) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

(h) "Former Employee" means any person formerly employed as an Employee.

(i) "Participant" means an Employee, Former Employee, and Dependents who meet the requirements for eligibility as set forth in Article II and who properly enroll in the Plan.

(j) "Participant Contribution" means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under the SPD, as may be amended from time to time, and which is attached hereto in Appendix B. The term "Participant Contribution" includes contributions used to purchase insurance contracts or policies.

(k) "Plan" means the Liberty Mutual Medical Plan, which consists of this document, the SPD incorporated hereunder by reference as may be amended from time to time, and any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B.

(l) "Plan Administrator" means the Company.

(m) "Plan Year" means each twelve (12) consecutive month period commencing [3] January 1 and ending on December 31.

(n) "SPD" means any summary plan description, as may be amended from time to time, summary of material modifications, or other employee communication, which describes the benefits under the Plan, and which has been included by the Employer as part of this Plan under Appendix B.

Section 1.4 Interpretation.

The Plan shall consist of the articles and appendices of this Plan document, the SPD, as may be amended from time to time, and any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B. If, as to any provisions of the SPD or HMO document, the articles of this Plan document provide explicitly to the contrary, the provisions of this Plan document shall control. If there is a conflict between the provisions of any of the articles of this

Plan document and the SPD or HMO document, and such conflict involves a provision required by ERISA or the Code, the provision required by ERISA or the Code shall control. The terms of this Plan document may not enlarge the rights of a Participant to benefits available under the Plan.

ARTICLE II. ELIGIBILITY AND PARTICIPATION

Section 2.1 Eligibility.

An Employee, Former Employee, and Dependents shall be eligible to participate in the Plan as provided under the terms of the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B.

Section 2.2 Enrollment.

The Plan Administrator may establish procedures in accordance with the SPD, as may be amended from time to time, for the enrollment of Employees, Former Employees, and Dependents under the Plan. The Plan Administrator may prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

Section 2.3 Termination of Participation.

A Participant will cease being a Participant in the Plan and coverage under this Plan for the Participant shall terminate in accordance with the provisions of the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants and which are attached hereto in Appendix B.

[4] ARTICLE III. FUNDING

Section 3.1 Funding.

Notwithstanding anything to the contrary contained herein, participation in the Plan by a Participant and the payment of Plan benefits attributable to Company or Employer contributions shall be conditioned on such Participant contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time ("Participant Contribution"). The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Company, an Employer, or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, except to the extent specifically required under the terms of the SPD attached hereto in Appendix B. No Participant shall have any right to, or interest in, the assets of the Company or any Employer.

Benefits are paid out of the Company's general assets, excluding HMOs and PacifiCare in-network benefits. Costs of coverage are shared by the Company and Employees.

ARTICLE IV. BENEFITS

Section 4.1 Benefits.

Benefits will be paid solely under the terms of, and in the form and amount specified in, the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants, and which are attached hereto in Appendix B.

ARTICLE V. CLAIMS

Section 5.1 Claims Procedure.

(a) Except as provided in Subsection (b), a claim for benefits shall be submitted to the claims administrator under the terms of the SPD as may be amended from time to time, and as may be provided in any document describing the HMO options which from time to time may be offered to Participants. A claim shall not be treated as having been filed until all information necessary to process the claim is submitted. In the event that a claim, as originally submitted, is not complete, the claims administrator shall notify the claimant and the claimant shall then have the responsibility for providing the missing information. If all information necessary to process a claim

is not submitted by the applicable claim filing deadline, the claim shall automatically be deemed to be denied.

[5] (b) In the event that the SPD or HMO document does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, the claims procedure described below shall apply.

(1) A claim shall be filed in writing and decided within ninety (90) days by the claims administrator unless special circumstances require an extension of up to ninety (90) additional days. Written notice of the decision on such claim shall be furnished promptly to the claimant and shall be written in a manner calculated to be understood by the claimant. If the claim is wholly or partially denied, such written notice shall:

(A) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan documents;

(B) describe any additional information or material needed to support the claim and explain why such information or material, if any, is necessary; and

(C) describe the claims review procedures in subsections (2) and (3).

(2) In the event a claim for benefits is denied, or if the claimant has had no response to such claim within ninety (90) days of its submission (in which case the claim for benefits shall be deemed to have been denied) the claimant or his duly authorized representative may request a review by the Plan Administrator of such decision denying the claim.

(A) Any such request must be filed in writing within sixty (60) days after receipt by the claimant of written notice of the decision or the date such claim is deemed to be denied. Such written request for review shall contain all additional information which the claimant wishes to be considered.

(B) In pursuing this review, the claimant or his duly authorized representative:

(i) must request in writing a review of the denial;

(ii) may review pertinent documents; and

(iii) may submit issues and comments in writing.

(3) Written notice of the decision on review shall be furnished to the claimant within sixty (60) days (unless special circumstances require an extension of up to sixty (60) additional days) following the

receipt of the request for [6] review. The written notice of the decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan on which the decision is based. If the decision on review is not furnished within the time specified above, the claim shall be deemed to be denied on review.

Section.5.2 Exhaustion of Administrative Remedies.

No action at law or in equity may be brought to recover under this Plan until all administrative remedies have been exhausted. If a claimant fails to file a timely claim or, if a claim is denied, fails to request a review in accordance with the procedures outlined herein, such claimant shall have no rights of review and shall have no right to bring any action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Section 5.3 Action for Recovery.

No action at law or in equity may be brought for recovery under this Plan until the date on which the Participant has exhausted all appeal rights, nor more than one year after the time written proof of claim is required to be furnished.

Section 5.4 Participant's Responsibilities.

Each Participant shall be responsible for providing the Plan Administrator and/or the Company with the Participant's current address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Company shall have any obligation or duty to locate a Participant.

ARTICLE VI. AMENDMENT AND TERMINATION

Section 6.1 Right to Amend.

The Board of Directors of the Company, a committee thereof, or a delegee of either, shall have the right to make at any time any amendment or modification to the Plan; but in no event shall any such amendment or modification prejudice any claim or benefit under the Plan which was incurred but not paid prior to the date of the amendment or modification. The Board of Directors has delegated to the Chief Executive Officer of the Company the authority to make any plan amendment required to bring the Plan into conformity with law or regulation.

Section 6.2 Right to Terminate.

The Board of Directors of the Company, a committee thereof, or a delegee of either, shall have the right at any time to terminate the Plan in whole or in part; but in no event shall such termination prejudice any

claim or benefit under the Plan which was incurred but not paid prior to the termination date.

[7] ARTICLE VII. ADMINISTRATION AND FIDUCIARY PROVISIONS

Section 7.1 Plan Administrator.

The Company shall be the "Plan Administrator." The Plan Administrator shall have overall responsibility for the administration of this Plan and any decisions made in accordance herewith shall be final and conclusive on all Employees. The Company may change or modify this responsibility in its sole discretion. All usual and reasonable expenses of the Plan Administrator may be paid in whole or in part by the Company and any expenses not paid by the Company shall not be the responsibility of the Plan Administrator.

Section 7.2 Powers and Duties of the Plan Administrator.

The Plan Administrator, and its designees as it relates to functions designated by the Plan Administrator, shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have complete and final discretionary authority to construe and interpret the Plan, control over the operation and administration of the Plan, including interpretation of all Plan documents, decisions concerning all

questions of eligibility to participate and the determination of the amount, manner and time of payment of any benefits hereunder. Without limitation, such decisions by the Plan Administrator and its designees as to the determination of all related or non-related questions and matters that arise under the Plan shall be final and conclusive, and there shall be no *de novo* review of any such decisions by any court. Any review of such decisions shall be limited to determining whether the decisions were so arbitrary and capricious as to be an abuse of discretion;

(b) to have control over the operation and procedures of the Plan, including prescribing procedures to be followed by Participants filing claims for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator and its designees determine to be appropriate, information explaining the Plan;

(d) to receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(e) to furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate;

[8] (f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses directed by the Plan Administrator;

(g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of the Participants and the balances which are payable under this Plan; and

(h) to appoint individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal counsel, consultants and actuaries.

The Plan Administrator and its designees may rely upon any reasonable direction, or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under this Plan, and are not required under this Plan to inquire into the propriety of any such direction or information. It is intended under this Plan that the Plan Administrator and its designees shall be responsible for the proper exercise of their own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act of the Employer. Neither the Plan Administrator nor the Employer make any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

Section 7.3 Outside Assistance and Payment of Expenses.

(a) Outside Assistance: The Plan Administrator may employ such counsel, accountants, claims administrators, consultants, actuaries and other person or persons as it shall deem advisable.

(b) Payment of Expenses: The Plan Administrator has the right to pay any Plan expenses out of existing Plan funds which in the Plan Administrator's discretion are allowable expenses under ERISA.

Section 7.4 Delegation of Powers.

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable it properly to carry out such duties.

Section 7.5 Indemnification of NonCorporate Fiduciaries and Plan Administrator.

In case the Plan Administrator or noncorporate fiduciaries of the Plan who are affiliated with the Company or an Employer as a director or officer of the Company or an Employer are involved in litigation related to the Plan, or a judgment is rendered against such parties, the Company, acting through its Board of Directors, a committee thereof, or a delegee of either, shall indemnify the Plan Administrator or

such noncorporate fiduciaries who are affiliated with the Company or an Employer as a director or officer of the Company or an Employer for any action taken in good faith in the administration of the Plan or in compliance with the requirements of the Plan.

[9] *Section 7.6 Named Fiduciaries.*

The following persons or entities are named as fiduciaries under the Plan:

(a) The Company – The Company, acting through its Board of Directors, a committee thereof, or a delegee of either, has chosen the Plan Administrator to be responsible for all fiduciary functions under the Plan, unless the function is explicitly delegated to another named fiduciary. The Plan Administrator has the authority, in its sole discretion, to construe the terms of this Plan and decide all questions of eligibility, determine the amount, time and manner of payment of any benefits and decide any other matters relating to the administration or operation of the Plan. Any such interpretations or decisions of the Plan Administrator shall be conclusive and binding.

(b) Other Named Fiduciaries:

(1) The Employer, or Employers, acting through their board of directors, shall be responsible for the funding of the Plan; provided, that the Plan's funding policy

and method shall be determined by the Company.

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. Any named fiduciary hereunder may, by resolution of its board of directors or pursuant to such formal procedures as it shall establish, designate persons (including third-party administrators) other than the named fiduciaries to carry out the fiduciary responsibilities under the Plan.

Section 7.7 Complete and Separate Allocation of Fiduciary Responsibilities.

It is intended that this Article VII shall allocate to each named fiduciary the individual responsibility for the prudent execution of the functions assigned to each named fiduciary. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. None of such responsibilities nor any other responsibility is intended to be shared by two (2) or more of such fiduciaries, unless such sharing shall be provided by a specific provision of the Plan or any agreement of trust. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two shall not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction shall be deemed to be its sole responsibility, and the responsibility of the one receiving such direction shall be to

follow it insofar as such direction is on its face proper under the Plan and applicable law.

Section 7.8 Disclaimer of Liability.

Except as otherwise provided under sections 404 through 409 of ERISA, neither the Board of Directors of the Company, the Employer, the board of directors of the Employer, the trustee (if any), the Plan Administrator, nor any person designated to carry out fiduciary responsibilities [10] pursuant to this Plan shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

ARTICLE VIII. EMPLOYERS

Section 8.1 Adoption of Plan.

This Plan may be adopted by an Employer, provided that such adoption is with the approval of the Company. Such adoption shall be by resolution of the Employer's governing body, a copy of which shall be filed with the Company.

Section 8.2 Administration.

As a condition to adopting the Plan, and except as otherwise provided herein, each Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

Section 8.3 Termination of Participation.

Each Employer may cease to participate in the Plan with respect to its Employees or Former Employees by resolution of its governing body, provided the Employer is authorized to do so by the Company, by formal written resolutions of the Company's Board of Directors (or the person, entity or group of persons appointed by the Board of Directors by action taken in accordance with its authority).

ARTICLE IX. MISCELLANEOUS

Section 9.1 Exclusive Benefit.

This Plan has been established for the exclusive benefit of Participants and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

Section 9.2 Non-Alienation of Benefits.

No benefit, right or interest of any Participant under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of the Plan. The Employer shall not be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant entitled to benefits hereunder.

[11] *Section 9.3 Limitation of Rights.*

Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to:

(a) give any person any legal or equitable right against the Plan (including any assets of the Plan) the Company or an Employer, except as expressly provided herein or required by law; or

(b) create a contract of employment with any Employee, obligate the Company or an Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way, including the right of the Company or an Employer to discharge any Employee, with or without cause.

Section 9.4 Governing Laws.

The Plan shall be construed and enforced according to the laws of the state of Massachusetts, to the extent not preempted by Federal law that shall otherwise control.

Section 9.5 Severability.

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

Section 9.6 Construction.

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

Section 9.7 Expenses.

Any expenses incurred in the administration of the Plan shall be paid by the Plan, by the Company and/or by one or more Employers, according to the Company's determination.

Section 9.8 Entire Plan.

This document constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

[12] *Section 9.9 Other Law*

The Plan shall comply with all other state and federal law to the extent not preempted by ERISA and to the extent such laws require compliance by the Plan.

IN WITNESS WHEREOF, the Company has caused this Plan to be effective January 1, 2001, except as otherwise stated herein, to be executed by its duly authorized officer.

LIBERTY MUTUAL INSURANCE COMPANY

By: /s/ Helen ER Sayles

Title: SVP – HR & Administration

[13] LIBERTY MUTUAL MEDICAL PLAN

APPENDIX A

In addition to **Liberty Mutual Insurance Company**, the following Employers have adopted the Plan pursuant to Section 8.1:

Colorado Casualty Insurance Company

Golden Eagle Insurance Corporation

Helmsman Management Services, Inc.

Liberty Insurance Holdings, Inc.

Liberty International Agency, Inc.

Liberty Mutual Fire Insurance Company

Liberty Life Assurance Company of Boston

Liberty Northwest Insurance Corporation

National Insurance Association

Summit Consulting, Inc.

The Netherlands Insurance Company

Wausau Service Corporation

Workwell Health & Safety, Inc.

[14] LIBERTY MUTUAL MEDICAL PLAN

APPENDIX B

The following documents shall form a part of the Plan pursuant to Section 1.3 herein:

Summary Plan Description for the Liberty Mutual Medical Plan.

Any communication describing the benefits under any HMO option which from time to time may be offered to Participants.

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum ("Addendum"), effective as of April 14, 2003 (the "Addendum Effective Date"), by and between Liberty Mutual Insurance Company ("Liberty Mutual"), on behalf of the Liberty Mutual Medical Plan, a Covered Entity ("CE"), and Blue Cross and Blue Shield of Massachusetts, Inc., a Business Associate of CE, ("Associate") supplements and is made a part of the Administrative Services Account Agreement between Liberty Mutual and Blue Cross and Blue Shield of Massachusetts, Inc. effective January 1, 1995 ("Agreement").

RECITALS

A. Associate may have access to, create, or receive Protected Health Information ("PHI") in the course of performing its functions and duties under the terms of the Agreement.

B. CE and Associate intend to protect the privacy of PHI in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and privacy regulations promulgated thereunder by the U.S. Department of Health and Human Services and other applicable laws.

C. The Privacy Rule requires CE to enter into a written contract or other written agreement or arrangement with Associate that meets the applicable requirements of Title 45, Sections 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR").

In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. *Definitions.*

a. *"Business Associate"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103.

b. *"Covered Entity"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103.

c. *"Data Aggregation"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

d. *"Designated Record Set"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

e. *"Health Care Operations"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

f. *"Privacy Rule"* shall mean the Standards for Privacy of Individually Identifiable Health Information set forth at 45 CFR Parts 160 and 164, Subparts A and E.

g. *"Protected Health Information" or "PHI"* shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103, limited to the information created or received by the Associate from or on behalf of CE.

2. *Obligations of Associate.*

a. *Permitted Uses and Disclosures.* Associate may use and/or disclose PHI to perform its obligations under the Agreement if such use or disclosure would not violate the Privacy Rule if done by CE. Notwithstanding the foregoing, Associate may also use or disclose PHI in accordance with Section 2.b. below.

b. *Additional Permitted Uses and Disclosures.* Associate may:

(i) Use PHI for the proper management and administration of Associate's operations or to carry out the legal responsibilities of the Associate;

(ii) Disclose PHI for the proper management and administration of Associate's operations or to carry out the legal responsibilities of Associate, provided that:

- The disclosures are required by law, or
- Associate obtains reasonable assurances from the person to whom the information is disclosed that said information will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Associate of any instances of which he or she is aware in which the confidentiality of the information has been breached;

(iii) Provide Data Aggregation services to the Plan as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B);

(iv) Report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. § 164.502(j)(1); and

(v) Use and disclose PHI as permitted or required by law, including but not limited to disclosing PHI for medical research studies in accordance with federal law.

c. *Appropriate Safeguards*. Associate shall use appropriate safeguards to prevent the use or disclosure of PHI other than as permitted by the Agreement and this Addendum.

d. *Mitigation*. Associate shall mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of PHI by Associate in violation of the Agreement and this Addendum.

e. *Reporting of Improper Use or Disclosure*. Associate shall promptly report to CE any use or disclosure of PHI other than as provided for by the Agreement and this Addendum of which Associate becomes aware. As of the compliance date for the HIPAA Security Standards Rule (45 C.F.R. Parts 160 and 164, Subpart C), Associate agrees to notify Sponsor of any Security Incident of which it becomes aware as required by the Security Rule.

f. *Associate's Agents*. Associate shall ensure that any agents of Associate, including subcontractors, to whom it provides PHI agree in writing to restrictions

and conditions comparable to those that apply through this Addendum to Associate with respect to such PHI.

g. *Access to Protected Information.* Associate shall make PHI in Designated Record Sets available to an individual who is the subject of such PHI for inspection and copying in accordance with 45 CFR Section 164.524.

h. *Amendment of PHI.* Associate will respond to requests for amendment(s) to PHI in a Designated Record Set in accordance with the terms of 45 CFR Section 164.526.

i. *Accounting Rights.* Upon request by an individual who is the subject of PHI for an accounting of disclosures of such PHI, Associate shall make available to such individual the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528. Associate will document such disclosures of PHI and information related to such disclosures as would be required for CE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. Section 164.528.

j. *Governmental Access to Records.* Associate shall make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining CE's compliance with the Privacy Rule.

k. *Minimum Necessary*. Associate shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure.

l. *Electronic Data Interchange*. Associate shall be capable of transmitting electronic data for which transaction standards have been promulgated in compliance with the HIPAA Electronic Transactions Rule, 45 CFR Parts 160 and 162, as of the effective date of such Rule, including any applicable implementation periods, and shall to the extent possible transmit electronic data in accordance with such Rule and the HIPAA contingency plan adopted by Associate.

m. *Security Standards*. Associate shall implement processes and safeguards to secure PHI in compliance with the Security Standards Rule (45 CFR Parts 160 and 164, Subpart C), as of the effective date of such Rule, including any applicable implementation periods. . If Associate is required by law to perform a function or activity on behalf of, or provide a service to, CE, CE and Associate will, at the request of either party, enter into good faith negotiations to permit Associate to create, receive, maintain, and/or transmit electronic PHI on CE's behalf to the extent necessary to comply with the legal mandate without meeting the requirements of this subsection 2(m) or subsection 2(e) above, in accordance with 45 C.F.R. § 164.314(a)(2)(ii)(B).

3. *Obligations of CE.*

a. CE will notify Associate immediately in writing of any limitation(s) in CE's notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation(s) may affect Associate's use or disclosure of PHI.

b. CE will notify Associate immediately in writing of any restriction to the use or disclosure of PHI that CE has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Associate's use or disclosure of PHI.

c. CE will notify Associate immediately in writing of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Associate's use or disclosure of PHI.

d. CE will not request that Associate use or disclose Protected Health Information in any manner that would be impermissible under the Privacy Rule if done by CE, provided that CE may request that Associate use or disclose Protected Health Information in accordance with paragraphs 2.a. and 2.b. above and paragraph 3.f. below.

e. CE shall only request from Associate the minimum amount of PHI necessary to accomplish the purpose of the request.

f. CE authorizes and permits Associate to disclose PHI to the Plan Sponsor. CE and Plan Sponsor represent that (i) the Plan documents have been

amended in accordance with 45 CFR 164.504(f)(2); (ii) the CE has received a certification by the Plan Sponsor that the Plan documents have been amended to comply with the requirements of 45 CFR 164.504(f) and Plan Sponsor will appropriately safeguard and limit the use and disclosure of PHI; (iii) the statement required by 45 CFR 164.520(b)(1)(iii)(C) has been included in the notice of privacy practice. CE will provide Associate with a written list of persons identified in the Plan document, as may be amended from time to time, as persons authorized to have access to PHI to carry out plan administration functions. The CE will provide Associate with an updated version of the list, in writing, immediately following any amendment to the Plan documents that changes the persons authorized to have access to Protected Health Information. Associate will disclose PHI in accordance with this subsection 3(f) only to persons included on the list provided to Associate.

4. *Termination.*

a. *Material Breach.* A breach by Associate of any material provision of this Addendum shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement.

b. *Reasonable Steps to Cure Breach.* If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum and does not terminate the Agreement

pursuant to Section 4(a), then CE shall provide an opportunity for Associate to take reasonable steps to cure such breach or end such violation, as applicable. If efforts to cure such breach or end such violation are unsuccessful, CE shall either (i) terminate the Agreement, if feasible or (ii) if termination of the Agreement is not feasible, CE shall report Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. *Effect of Termination*. Upon termination of this Agreement, Associate will

(i) Retain all Protected Health Information in its possession in accordance with Associate's record retention policies and applicable law;

(ii) Extend the protections of this Addendum to the retained Protected Health Information; and

(iii) Notwithstanding any interpretation of section 4.c.ii to the contrary, comply with the obligations set forth in sections 2.g., 2.h., 2.i., and 2.j. provided that CE agrees to reimburse Associate for the reasonable costs associated with such obligations.

5. *Indemnification*. Associate shall indemnify and hold harmless CE and Liberty Mutual, and its parents, subsidiaries, and affiliates, and their respective directors, officers, employees, attorneys, and agents, past and present, from any and all claims, damages, suits, losses, penalties, demands, costs, liabilities, settlements, attorney's fees, judgments, and expenses of any kind arising from, in connection with, or related

to the acts or omissions under this Addendum of Associate or any of its subcontractors, employees, representatives, or agents. CE shall indemnify and hold harmless Associate, and its subsidiaries and affiliates, and their respective directors, officers, employees, attorneys, and agents, past and present, from any and all claims, damages, suits, losses, penalties, demands, costs, liabilities, settlements, attorney's fees, judgments, and expenses of any kind arising from, in connection with, or related to the acts or omissions under this Addendum of CE or any of its subcontractors, employees, representatives, or agents.

6. *Amendment*. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to amend this Addendum from time to time as is necessary for CE to comply with the requirements of Privacy Rule and HIPAA. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all PHI. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the Privacy Rule or other applicable laws and regulations.

7. *No Third Party Beneficiaries*. Nothing express or implied in this Agreement is intended to confer, nor

shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8. *Effect on Agreement.* Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect.

9. *Interpretation.* The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the Privacy Rule.

10. *Survival.* This Addendum will survive termination of the Addendum and the Agreement solely with respect to Protected Health Information retained in accordance with section 4.c. above for so long as such information is retained. In addition, section 5 shall survive termination of this Addendum.

11. *Regulatory References.* A reference in this Addendum and in the Agreement to a section in the Privacy Rule means the section as in effect or as amended.

12. *Notices.* Any notices required under this Addendum shall be in writing and delivered in person or mailed by registered or certified mail or by overnight courier to the following addresses:

To CE: Liberty Mutual Insurance Company,
On Behalf of the Liberty Mutual Medical Plan
175 Berkeley Street
Boston, MA 02117
Attention.: Mgr Health Plans

To Associate: Blue Cross and Blue Shield of Massachusetts, Inc.
Landmark Center
410 Park Drive
Boston, Massachusetts 02215-3326
Attention: Contracts Administration

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the Addendum Effective Date.

/s/ Helen ER Sayles
Liberty Mutual Insurance Company
of [sic] behalf of Liberty Mutual Medical Plan

/s/ Stephen R Booma
Blue Cross and Blue Shield of Massachusetts, Inc.

AMENDMENT TO HIPAA BUSINESS ASSOCIATE ADDENDUM

This Amendment entered into by and between Blue Cross and Blue Shield of Massachusetts, Inc. ("Associate") and Liberty Mutual Group Inc. ("Liberty Mutual") on behalf of the Liberty Mutual Medical Plan ("CE") is effective February 17, 2010 ("Amendment Effective Date") and is made part of that certain HIPAA Business Associate Addendum between the parties ("Addendum") that forms part of that certain Administrative Services Agreement ("Agreement") effective January 1, 1995 entered into by and between the Liberty Mutual and Associate.

A. Whereas the parties previously have entered into the Addendum to protect the privacy and provide for the security of PHI in compliance HIPAA and the HIPAA Regulations and other applicable laws;

B. Whereas the parties now wish to amend such Addendum to comply with the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("HITECH") and HITECH regulations and guidance;

Now, therefore, in consideration of the mutual promises contained herein and in the Agreement, the parties agree to supplement the Addendum and Agreement by adding the following new provisions:

1. Definitions.

a. "Breach" shall have the meaning given to such term under HITECH § 13400 and any HITECH regulations and guidance including, but not limited to, 45 CFR § 164.402.

b. "Electronic Health Record" shall have the meaning given to such term under HITECH § 13400.

c. "Unsecured Protected Health Information" or "Unsecured PHI" shall have the meaning given to such term under HITECH regulations and guidance including, but not limited to, 45 CFR § 164.402.

d. Any terms used, but not otherwise defined, in the Addendum and this Amendment shall have the same meaning as those terms have under HIPAA, HITECH, and the HIPAA Regulations.

2. HITECH Standards and Requirements.

Notwithstanding any other provision in this Amendment, no later than February 17, 2010, unless a separate effective date is specified by applicable law or this Amendment for a particular requirement (in which case the separate effective date shall be the effective date for that particular requirement), Associate shall comply with HITECH and HITECH guidance, regulations, standards, and requirements, including but not limited to:

(i) individual requests for restrictions on use or disclosure of PHI to health plans for payment or health care operations purposes when the

individual has paid the provider out of pocket in full consistent with HITECH § 13405(a);

(ii) compliance with the requirements regarding "minimum necessary" consistent with HITECH § 13405(b); Associate understands and agrees that the definition of "minimum necessary" is in flux and shall monitor guidance issued by the Secretary with respect to what constitutes "minimum necessary;"

(iii) effective as of the compliance date set forth in HITECH § 13405(c) or as of the separate compliance date set forth in HITECH regulations, the requirements regarding accounting of certain disclosures of PHI maintained in an Electronic Health Record under HITECH § 13405(c) to the extent Associate discloses any PHI maintained in an Electronic Health Record;

(iv) the prohibition on sales of PHI without authorization unless an exception applies consistent with HITECH § 13405(d);

(v) the provision of access to certain information in electronic format consistent with HITECH § 13405(e);

(vi) the requirements under HITECH § 13406 relating to marketing, the prohibition on receiving remuneration for certain communications that fall within the exception to the definition of marketing unless permitted by HITECH § 13406, and the provisions relating to opt-out of fundraising communications; and

(vii) compliance with each of the Standards and Implementation Specifications of 45 C.F.R.

§§ 164.308 (Administrative Safeguards), 164.310 (Physical Safeguards), 164.312 (Technical Safeguards) and 164.316 (Policies and Procedures and Documentation Requirements).

If Associate knows of a pattern of activity or practice of CE that constitutes a material breach or violation of CE's obligations under the provisions of the Addendum or Amendment, Associate shall provide an opportunity for CE to take reasonable steps to cure such breach or end such violation, as applicable. If efforts to cure such breach or end such violation are unsuccessful, Associate shall either (i) terminate the Agreement, if feasible or (ii) if termination of the Agreement is not feasible, Associate shall report CE's breach or violation to the HHS Secretary.

Associate acknowledges that Associate is subject to same civil and criminal penalties as CE if Associate violates the HIPAA privacy and security requirements as set forth in the Business Associate Addendum between the parties including this Amendment.

3. Notification of Breach of Unsecured PHI.

In addition to any other notification and reporting obligations in the Agreement and Addendum, Associate shall notify CE of any significant impermissible acquisition, access, use or disclosure of PHI. Associate shall notify CE of any Security Incident and any Breach of Unsecured PHI which Associate "discovers," consistent with HITECH regulations including 45 CFR § 164.402 and 45 CFR § 164.410, without

unreasonable delay and in no case later than five (5) business days after such discovery.

Associate shall take (i) prompt corrective action to cure any such deficiencies, (ii) any action pertaining to such impermissible acquisition, access, use or disclosure or Breach of Unsecured PHI required by applicable federal and state laws and regulations, and (iii) indemnify and hold harmless CE and Liberty Mutual for any claims, costs, fines, penalties, and expenses, including the cost of notification and on-going monitoring services, arising from any such impermissible acquisition, access, use or disclosure of PHI or Breach of Unsecured PHI.

If the parties determine there is a reportable Breach of Unsecured PHI, Associate will provide all HITECH-required notices to affected individuals, in accordance with all applicable requirements and timeframes under HITECH and the HITECH regulations. Associate will provide CE a copy of any proposed notice or communication before providing the notice or communication to individuals.

Associate shall maintain all documentation required under 45 CFR § 164.414(b).

All other terms and conditions of the Agreement and Addendum shall remain in full force and effect. In the event of any conflict between the terms and conditions of this Amendment and the terms and conditions of the Agreement and Addendum, this Amendment shall prevail.

IN WITNESS WHEREOF, the parties hereto have duly executed this Amendment as of the Amendment Effective Date.

/s/ Helen ER Sayles	/s/ Timothy J. O'Brien
Liberty Mutual Group Inc. on behalf of Liberty Mutual Medical Plan	2/18/10 Blue Cross and Blue Shield of Massachusetts, Inc.

[LOGO] **BlueCross BlueShield of Massachusetts**

The Health Services Company™

An Independent Licensee of the
Blue Cross and Blue Shield Association

ADMINISTRATIVE SERVICES AGREEMENT entered into by and between Blue Cross and Blue Shield of Massachusetts, Inc. and Liberty Mutual Insurance Company

Blue Cross and Blue Shield of Massachusetts, Inc. (Blue Cross and Blue Shield) will administer health care benefits for your covered employees and their covered dependents according to the health care benefits detailed in your ERISA plan documents attached to and incorporated in this Agreement as Attachment A. We will administer benefits for these members as long as they meet the eligibility requirements of your ERISA plan documents and as long as the applicable charges are paid.

In this Agreement, the terms we, us, and our refer to Blue Cross and Blue Shield. The terms you and your refer to the account that has entered into this Agreement as shown by the authorized signatures in Section 10 below.

You, on your own behalf and on behalf of your covered employees, hereby expressly acknowledge your understanding that this Agreement constitutes a contract solely between you and Blue Cross and Blue Shield of Massachusetts, Inc. (Blue Cross and Blue Shield) which administers both Blue Choice Plan 2 and Select Blue for Pennsylvania Employees, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that Blue Cross and Blue Shield is not contracting as the agent of the Association. You, on your own behalf and on behalf of your covered employees, further acknowledge and agree that you have not entered into this Agreement based upon representations by any person other than Blue Cross and Blue Shield and that no person, entity, or organization other than Blue Cross and Blue Shield will be held accountable or liable to you for any of Blue Cross and Blue Shield's obligations to you created under this Agreement. This paragraph will not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield other than those obligations created under other provisions of this Agreement.

Section 1. Term of This Agreement

This Agreement will be effective for the term stated in Attachments A, B and C unless terminated

as described in Section 8 below, and will be automatically extended from year to year on your anniversary/renewal date. Attachments A, B and C are incorporated as part of this Agreement and may be amended from time to time upon mutual written agreement. We will deliver your renewal rates 180 days prior to your anniversary/renewal date.

The initial term of this Agreement begins on January 1, 1995.

Section 2. General Terms of This Agreement

You will be solely responsible for complying with all applicable provisions of the Employee Retirement Income Security Act of 1974, as amended. This includes the fiduciary responsibilities of structuring your health benefit plans and maintaining adequate funding to support these plans. You will also be responsible for providing your covered employees with copies of the ERISA plan documents describing your health benefit plans and with copies of a summary brochure of benefits, limitations, exclusions and waiting periods.

You will be solely responsible for any health care benefits or services that you must provide under any applicable employer's liability or indemnification law or under any workers' compensation act.

You will be solely responsible for collecting any charges that you assess for your employees.

In the event that we are subject to federal or state laws or regulations mandating a change in the benefits of your health benefit plans or in the eligibility of covered employees and their covered dependents, we will implement such mandatory change. If your charges are to be increased, we will give you 60 days prior written notice of prospective adjustments. When you are subject to federal or state laws or regulations, these changes will be effective on the date you specify, provided we receive prior written notice. You agree to hold us harmless for any charges, including legal fees, judgments, administrative expenses and benefit payment requirements, that may result at any time arising from or in connection with your self-insured ERISA health benefit plan or due to your failure to comply with any laws or regulations, unless caused by an error on our part and/or by dishonest, fraudulent or criminal conduct by us or our agents. This includes, but is not limited to, any non-compliance with mandated benefits provisions and the Medicare secondary payor provisions. This indemnification provision will continue in effect after termination of this Agreement for any reason.

You agree to indemnify and hold us harmless for any taxes and assessments, including penalties and interest, or any other amounts legally levied based on the terms of this Agreement. We agree to notify you of any action as soon as possible. This provision applies to any amounts imposed, now or later, under the authority of any federal, state or local taxing jurisdiction.

This provision will continue in effect after termination of this Agreement for any reason.

This Agreement may be amended only by written agreement of both parties. A waiver for any breach of this Agreement will not be construed to be a continuing waiver for a similar breach. Such a waiver must be in writing and signed by authorized representatives of both parties to be effective.

We will not use or publish in any of our advertisements, external publications, client lists, press releases or similar statements your name, logo, or other name or marks associated with you without your prior written consent. Notwithstanding the foregoing, we may, in conversation with particular prospective customers, make reference to the fact that you selected us as one of your health care providers (provided in the statements with respect to you are truthful and not misleading); and we may (without your prior consent), in responses to requests for proposal in individual bid situations, include your name in a listing of employers who have selected us as one of your health care providers for your employees.

Section 3. Enrollment and Membership Requirements

The effective date or termination date of a covered employee's (and his or her dependents') membership will be the date you specify in written notice as long as that date is no more than 60 days before the date we receive your written notice and you pay the

applicable charges. This 60-day retroactivity provision will apply except as otherwise required by federal law or specified in the ERISA plan documents for your health benefits plans.

When a member is no longer eligible for group coverage, he or she may have the option to continue coverage as provided by state or federal law. You must provide all required continuation of coverage notices to the member.

Section 4. Benefits/Claims Liability

We will administer benefits based on your ERISA plan documents that are in effect for the covered member at the time the services are furnished. No action may be brought against us for failure to provide benefits unless brought within two years from the time the cause of action arises.

We will use the degree of ordinary care and reasonable diligence in the exercise of our powers and duties under this Agreement that an administrator of claims under an insured or uninsured employee benefit plan would use acting in like circumstances and familiar with such matters.

You must provide us with a current and updated listing of covered employees. You will be responsible for all costs and expenses associated with failure to maintain an accurate and current listing with us, unless such costs and expenses are due to an error on our part.

We will make recoveries for you through application of the subrogation, coordination of benefits, and workers' compensation provisions of your ERISA plan documents describing your health benefit plans to the extent allowed by contractual agreements with providers. Recoveries, if any, will be credited to you at the time of such recovery.

Upon the effective date of this Agreement, and for the duration of this Agreement, we will have in place a quality assurance program designed to provide quality medical services and care in an efficient and cost effective method to each covered member.

We represent and warrant that beginning with the effective date of this Agreement and for the duration of this Agreement, our quality assurance program is reasonable and customary for similarly situated companies in the same or like business as us and that we know of no material deficiencies in our quality assurance program, nor have any material deficiencies been alleged by any person or entity.

Effective January 1, 1998, we will pursue recoveries of fraudulent claims identified through our fraud and abuse detection activities. Our costs for fraud and abuse prevention and detection are included in the administrative charges described in the applicable Attachments to this Agreement. However, investigative costs to pursue recoveries are not. In the event we pursue and obtain a recovery of fraudulent claims, we may retain a portion of the recovery to support our costs. The balance of the recovery will be

credited to you at the time of the recovery. We will not charge you for our investigative costs if we do not obtain a recovery.

Effective January 1, 1999, we may contract with a consultant to identify and pursue claim recoveries through various types of specialized audits. In the event that such a claim recovery is obtained by the consultant, we will retain, on a claim by claim basis, the portion of the recovery that we reimburse to the consultant for these services. The balance of the recovery will be credited to you. We will not charge you for our costs if our consultant does not obtain a recovery.

You will be liable for claims incurred after a member's termination date until the date we receive your electronic or written notice of the member's termination date. You will also be liable when, under certain conditions detailed in your ERISA plan documents describing your health benefit plans, benefits continue beyond the termination date.

We agree to indemnify you and hold you harmless against any and all loss, liability, damage, expense, cost or obligation (including reasonable attorney's fees) with respect to this Agreement resulting from or arising out of the dishonest, fraudulent or criminal acts of our employees or agents acting alone or in collusion with others, or for that portion of such loss, liability, damage, expense, cost or obligation that an arbitrator determines was the result of or arose out of acts of our employees or agents in providing such

service under this Agreement not in compliance with the provisions as described above. This provision will survive termination of this Agreement.

Both parties desire that any dispute concerning this Agreement be handled out of court. Accordingly, the parties agree that any such dispute will, as the parties' sole and exclusive remedy, be submitted to expedited arbitration in Suffolk County, Massachusetts before an experienced health care arbitrator licensed to practice law in Massachusetts and selected in accordance with the standard rules of the American Arbitration Association (AAA). Both parties agree to waive any right of appeal to a court following arbitration. Should either party start any legal action or administrative proceeding against the other with respect to any claim waived by this Agreement, or pursue any method of resolution of a dispute other than mutual agreement of the parties or arbitration, then all damages, costs, expenses and attorney's fee incurred by the other party as a result will be the responsibility of the party bringing the suit or starting the proceeding.

Section 5. Reports

We will provide you with a paper copy of a monthly claims listing. This claims listing will include those claims we have paid in a specified month and year, itemized by identification number, patient name, date of service, claim number, and paid amounts. You may elect to receive the monthly claims

listings in an alternative format, such as on tape, in a mutually agreed upon format at an additional charge as described in the Attachment for Paid Claims Information. Signing the Attachment for Paid Claims Information will initiate your request for production of this type of claims listing and that Attachment will be incorporated as part of this Agreement.

Other information provided under this Agreement may include paper copies of rate quotations, membership lists and standard cost and utilization reports.

If you enter into a separate confidentiality and indemnification agreement with us to the extent permitted by law, we will also provide information that is available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of covered members.

You will use any information we make available solely for the purpose of administering your health care plans under this Agreement and as otherwise authorized by the covered member or the covered member's representative. You agree to hold us harmless for any claim, action or loss that may arise at any time in the future out of your unauthorized use of this information. Furthermore, if you use the information for another purpose, we will consider that action material breach. This Agreement will then be subject to immediate termination.

We will provide you with a monthly reserve estimate for incurred but not processed claims.

Section 6. Audits

If you dispute a charge that is included on your monthly claims listings, you must notify us of those amounts you dispute. You must still pay us the amount due us. If we verify that the charges are not your responsibility, we will credit you with the disputed amount.

When you dispute claim payments, you have the right at any time during regular business hours to review the data that supports our claim payments. Requests for this information must be made to us in writing. For disputed claim requests received on or after January 1, 1997, you must pay us an amount equal to 10% of the paid claim amount if we receive your request more than two years from the date the disputed claim was paid or denied.

Each year, you have the right to request, at your expense, a comprehensive audit of our claim payment records to ensure that our administration of the covered health care benefits is performed according to the terms of this Agreement and your ERISA plan documents describing your health benefit plans. These audits will be conducted only for claims processed within the previous two years of the date the audit is requested and according to the audit procedures we agree to with you prior to the start of the audit. We maintain auditable documentation for only a two-year period. Confirmed claim payment errors identified in the audit will be promptly corrected on a claim by claim basis under the normal recovery

process. You are not permitted to use extrapolation methodologies to calculate the financial impact of errors in a population of claim payments on the basis of a sample drawn from that population.

Indemnification. You agree to indemnify and hold us harmless from any loss, liability, damage or expense (including reasonable attorney's fees) which may result from any claim, demand, lawsuit or preceding arising out of the disclosure of information by us to you or your employees or agents in connection with the audit, or your failure or your employees or agents failure to maintain the confidentiality of any personal information in the claim records reviewed.

Auditor Qualifications. We require that you enter into an Audit and Confidentiality Indemnification Agreement with us prior to your audit. You will utilize individuals to conduct audits on your behalf who are qualified by appropriate training and experience for such work. You will also require them to perform their review in accordance with published administrative safeguards or procedures against unauthorized disclosure, in the audit report or otherwise, of any individually identifiable information (including health care information) contained in the claim records to be audited and will not make or retain any record of patient identifying information concerning treatment of drug or alcohol abuse, mental health conditions or AIDS in connection with any audit. If you use a firm to do the audit, it must be a mutually acceptable CPA firm or nationally recognized consulting

firm and that firm must enter into an Audit and Confidentiality Indemnification Agreement as well.

Identification of Audit Sample. During the audit, the auditors will provide a listing of the transactions selected for testing and the guarantee (payment dollar accuracy or overall accuracy) for which each item is being tested.

Closing Meeting. The auditors will identify, in writing, sample items which they believe to be in error and the nature of the error. This will provide the basis for a discussion to resolve disagreement and a summarization of the audit findings.

Random Selection of Audit Sample. The sample must be selected based on a random sampling methodology. Certain transactions defined by diagnosis (for example, mental conditions or AIDS/ARC) are excluded from the population because of legal requirements.

Size of Audit Sample. The audit sampling methodology must be thoroughly understood and endorsed for appropriateness in our business environment. A statistically valid sample size usually is from 100 to 150 claims, depending upon the universe from which the sample will be selected. (Generally, the sample is based on a 95% confidence level with an expected error rate not over 3% and precision of plus or minus 3%.) If the size of the sample is significantly outside of this range, you may be responsible for an additional administrative fee.

Section 7. Reopenings

You will conduct regular annual enrollment periods on your anniversary/renewal date. This will be done in order to change rates and/or benefits and, when you offer benefit choice to your employees, to give them an opportunity to select an alternative health benefit plan for the next policy year.

Section 8. Termination of This Agreement

This Agreement may be terminated upon written notice for material breach, fraud or misrepresentation, subject to notice and right to cure within 21 days, except if a longer period is provided under the terms of this Agreement.

This Agreement may also be terminated by either party as of the last day of any policy year upon 120 days prior written notice to the other.

This Agreement will be terminated in the event that you do not pay to us the total of all charges you owe us, as described in the applicable Attachments to this Agreement. If full payment is not received on or before the due date, we will suspend all claim payments as of the last date through which you have paid charges to us. If full payment is not received within 30 days after the due date, we will terminate this Agreement as of the last date through which you have paid charges to us.

This Agreement will automatically terminate in the event that you file for bankruptcy. In this case,

termination will be effective on the date you file for bankruptcy. You must accept a premium financial arrangement in order to continue health care coverage with us.

In the event that we file for bankruptcy, we become insolvent or we are placed in voluntary or involuntary receivership or rehabilitation, you will have the option to terminate this Agreement by providing us with written notice.

Upon termination, you may elect to have us continue our administration of any incurred but unreported claims and accrued but unpaid claims by paying us as described in Attachment A.

Section 9. Notices

Notices under this Agreement will be mailed by first class mail (postage paid) or delivered by hand to your address as listed in your annual renewal package and to our address as follows:

Blue Cross and Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, MA 02110

A notice will be deemed received by the close of business on the fifth business day after the date it is mailed.

Section 10. Acceptance

This Agreement and Attachments A, B and C and the provisions in your annual renewal package that

are referenced in your Agreement constitute both parties' entire understanding and supersedes all prior representations and understandings, whether oral or written, and will be governed by and construed according to the laws of the Commonwealth of Massachusetts.

This Agreement has been executed in duplicate by the authorized representatives whose signatures appear below:

Blue Cross and Blue Shield of Massachusetts, Inc.	**Liberty Mutual Insurance Company**
/s/ Donna L. Morris	Name:/s/ Helen ER Sayles
Donna L. Morris, Director Contracts Development	
/s/ W. Patrick Hughes	Title:Sr. Vice President HR & Admin
W. Patrick Hughes, Senior Vice President Sales, Marketing and Product Management	
Dated: 8/9/99	Dated: 11/22/99

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The Health Services Company™

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Attachment A
For Administrative Services Agreement

Health Benefit Plans

For the term January 1, 1995 through December 31, 1999, the following documents describe your health benefit plans:

Managed Care Plans:

Liberty Mutual Medical Plan referred to as Point-of-Service Plan in the Summary Plan Description, as the same has been and may be amended from time to time.

Acceptance

This Agreement has been executed in duplicate by the authorized representatives whose signatures appear below:

Blue Cross and Blue Shield of Massachusetts, Inc.	**Liberty Mutual Insurance Company**
/s/ Donna L. Morris	Name: /s/ Helen ER Sayles
Donna L. Morris, Director Contracts Development	

/s/ W. Patrick Hughes
W. Patrick Hughes, Senior Vice President Sales, Marketing and Product Management

Dated: _____

Title: Sr. Vice President HR & Admin

Dated: 11/22/99

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Attachment B
For Administrative Services Agreement

Cost Reimbursement
With Level Weekly Payments

For the term January 1, 1995 through December 31, 1999, the following provisions will apply:

Your Health Care Costs

Under this Cost Reimbursement arrangement, you will pay all health care costs incurred by covered members during the term of this Agreement and paid by us. Your health care costs consist of claim payments incurred by your members and which are covered under the terms of your Plan. Claim payments are the amounts we pay providers for your members' health care benefits when billed by the provider. We will administer your health care benefits based on the plan documents describing the health benefit plans you offer (see Attachment A) and on contractual agreements with providers. (We will administer your health care benefits for services furnished by covered non-contracting providers based on your plan documents and consistent with the providers' charges.) You will pay all claim payments incurred by members during the term of this Attachment.

Claim Payments and Provider Settlements. In Massachusetts, under fee-for-service contractual agreements with providers, claim payments reflect the rate of payment in effect at the time the claim is paid, but this rate does not include either positive or negative effects of any later contractual settlements with the providers. You will not be billed for or receive credit for any such settlements.

Effective on and after January 1, 1997, your administrative charge will include a credit or debit that reflects an average member allocation of the contractual settlement monies we project will be attributable to claims incurred over the term of this Agreement. We will select an independent auditor to review and approve this projection annually. You agree that this credit is the full and final amount you will receive from us related to any contractual settlements with providers attributable to claims incurred over the term of this Agreement.

Claim payments for Massachusetts acute care hospital and ambulatory surgery center services include an additional portion that is paid by Blue Cross and Blue Shield to the Massachusetts Uncompensated Care Pool in accordance with state law.

Additional Health Care Costs. For the managed care plans offered under this Agreement, you must pay certain additional health care costs incurred by your members during the term of this Agreement. These additional health care costs consist of the following payments to providers as applicable

under provider agreements: capitation payments and member management fees. Member management fees are set for certain periods of time based on the provider's performance and vary from provider to provider. They compensate providers for member management functions and reward them for effective member management.

In addition, for covered services and supplies furnished in Massachusetts, claim payments also include Blue Cross and Blue Shield health center encounter services and the amount we withhold from claim payments to providers when applicable under provider agreements. When a provider's contract includes provisions for withholding some of his or her claim or capitation payments and/or provisions for provider repayment of excess claim payments (including risk-sharing arrangements), we pay the withheld amounts to the provider if the provider's aggregate performance meets or is below the target we set.

Effective on and after January 1, 1997, if, after we settle with providers, any of the withheld funds are not paid to providers or we receive any repayments of claims payments in excess of the target, we will refund to you an aggregate pro rata share of these amounts. We will let you know the method we use to calculate your aggregate pro rata share (if any). In addition, if after settlements, providers earn payments in excess of the withheld amounts, we will debit you for your share of the excess payments. We will let you know the method we will use for allocating this debit.

Out of State Health Care Costs. If your member incurs health care costs outside of Massachusetts, in most other states, as in Massachusetts, claim costs reflect the rate of payment in effect at the time the claim is paid, but do not include either positive or negative effects of any later settlements with the providers. However, other Blue Cross and Blue Shield Plans may operate differently; for example, some Blue Cross and Blue Shield Plans do directly reflect both positive and negative effects of provider discounts or settlements, and some Plans retain a percentage of their discount or have other arrangements with providers. Our bills to you reflect the bills we receive from the other states' Plans. We will not bill you more than the other states' Plans bill us. In addition, we will not be responsible for determining the basis of provider payments passed through to us by any other Blue Cross and Blue Shield Plan.

Access Fees for Out of State Claims. Effective on and after January 1, 1996, for covered services and supplies furnished outside Massachusetts, we may be charged an "access fee" by the local Blue Cross and Blue Shield Plan. This fee is for access to the local Plan's negotiated payment rates and the resulting savings available to you and to members. (The access fee may be up to 10% of the local Plan's discount with a $2,000 cap per claim. We will notify you in writing in the event these limits are ever changed.) A Plan will charge an access fee only if its provider agreements prohibit billing members for amounts in excess of the negotiated payment rate. When we are charged

an access fee, we will pass the charge along to you as a claims expense. If we receive an access fee credit, we will give you a claims expense credit. Access fees are considered a claims expense because they represent claims dollars we were unable to or, in the case of a credit, able to avoid paying. Instances may occur in which we do not pay a claim (or pay only a small amount) because the amounts eligible for payment were applied to the deductible or coinsurance. If the local Blue Cross and Blue Shield Plan's arrangement with its provider allows the negotiated payment rate to apply when the amount is fully or mostly a patient obligation, we will pay the local Plan's access fee and pass it along to you as a claims expense even though we paid little or none of the claim.

Termination. If your Agreement with us is terminated, you with still be liable for all health care costs (including the amount set aside for provider incentives where applicable) incurred prior to the termination date but paid by us after the termination date. We will continue to be paid by the ACH credit transaction process set forth below. Both parties will agree to the amount of this weekly payment amount prior to the termination date. This amount will be adjusted upon agreement of both parties.

Administrative Charges

To your health care costs, we will add an administrative charge to support our administration of benefits. Your administrative charge is a fixed dollar

amount for each covered employee for each month. Your administrative charge is:

- $23.75 for each covered employee for the term January 1, 1995 through December 31, 1995.
- $24.70 for each covered employee for the term January 1, 1996 through December 31, 1996.
- $24.25 for each covered employee for the term January 1, 1997 through December 31, 1997.
- $32.74 for each covered employee for the term January 1, 1998 through December 31, 1998.
- $34.70 for each covered employee for the term January 1, 1999 through December 31, 1999.

Your administrative charge is considered "fully incurred." This means that the total administrative charges that you pay during the term of this Attachment support our administration of benefits for all health care costs incurred during any term of your Administrative Services Agreement. We will not bill you for any additional administrative charges to support our administration of continuing or run-off health care costs that we pay after the termination date.

During the term January 1, 1995 through December 31, 1996, your prescription drug benefits will be administered through our pharmacy vendor. If we

receive a rebate through our vendor, we will credit you with 70% of that rebate and retain the other 30% to cover our administrative costs for the pharmacy program. This provision will not apply to your health benefit plans on and after January 1, 1997.

Your Payments

Weekly Working Capital Amount. You have agreed to pay a mutually agreed upon fixed weekly working capital amount to us for estimated health care costs. On a quarterly basis, this fixed weekly working capital amount will be reviewed and adjusted accordingly for adequacy subject to approval of both parties.

Your fixed weekly working capital amount is:

- $75,000 for the term January 1, 1995 through December 31, 1995.
- $70,100 for the term January 1, 1996 through December 31, 1996.
- $50,000 for the term January 1, 1997 through December 31, 1997
- $46,000 for the term January 1, 1998 through December 31, 1998.
- $46,000 for the term January 1, 1999 through December 31, 1999.

Weekly Electronic Credit Transactions. You will initiate an ACH credit transaction on the first four Wednesdays of each month.

At three-month intervals, we will determine if the total of your weekly credit transaction amount was enough to cover your health care costs for the preceding period. In the event the total of your weekly credit transaction amount exceeded your health care costs, we will deduct the amount of that difference, with no interest, from what you owe us for your first weekly electronic credit transaction of the following month. However, in the event your health care costs exceed the total of your weekly credit transaction amount, we will add the amount of that difference, with no interest, to your first weekly electronic credit transaction of the following month.

Monthly Charges.

Pay as Billed Payments. For the period January 1, 1995 through June 30, 1996, we will provide you with a separate monthly invoice that indicates your total administrative charges due. You must pay the total of these charges on or before the due date indicated on your monthly invoices.

Self Bill Payments. For the period beginning on or after July 1, 1996, we will provide you with a separate monthly invoice that indicates your administrative charge amount plus your member management fees or other similar fees for each contract, and through December 31, 1996, capitation fees for your Western Pennsylvania members. Then, you will calculate your enrollment for the month that we bill you and forward the total amount due us for each contract. You must pay the total of these charges on

or before the due date indicated on your monthly invoices.

We will perform a quarterly audit to verify that the total enrollment that you submit to us coincides with the total enrollment that we indicate on our records. Any difference in this enrollment must be resolved by both parties within 30 days of the audit. You must pay to us any amount due for administrative charges and member management fees and capitation amounts within 30 days after the date we notify you of the amount due.

Late or Overdue Payments

We anticipate that payments for all charges will be received by the due date. If we do not receive full payment on or before the fifteenth day after the due date, we will suspend all claim payments as of the last date through which you have paid charges to us. In addition, we reserve the right to assess a finance charge on the amount that is past due. The first time in a policy year that we do not receive payment of all charges by the due date, the finance charge will be calculated from the fifteenth day after the due date at a rate of 1.5% per month. In the event we do not receive payment of all charges by the due date later in that policy year, the finance charge will be calculated from the due date at a rate of 1.5% per month.

Any provision in this Agreement to the contrary notwithstanding, if full payment is not available within seven days after the due date, we will send

you written notice that claims will be suspended if payment is not made available within 15 days after the due date. If full payment is not available within 15 days after the due date, we will suspend your claim payments and send you a written notice that the Agreement will be terminated if full payment is not available within 30 days after the due date. If full payment is not available within 30 days after the due date, termination will be effective as of the last date through which you have paid charges to us.

If you fail to make timely payments, we will have the right of setoff against your working capital amount described above.

Acceptance

This Agreement has been executed in duplicate by the authorized representatives whose signatures appear below:

Blue Cross and Blue Shield of Massachusetts, Inc.	**Liberty Mutual Insurance Company**
/s/ Donna L. Morris	Name:/s/ Helen ER Sayles
Donna L. Morris, Director Contracts Development	
/s/ W. Patrick Hughes	Title:Sr. Vice President HR & Admin
W. Patrick Hughes, Senior Vice President Sales, Marketing and Product Management	
Dated: 8/9/99	Dated: 11/22/99

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[B-1] **B**

MEDICAL PLAN
(For Active Employees)

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[B-4] **B**

MEDICAL PLAN

Overview

The Liberty Mutual Medical Plan ("Medical Plan") offers eligible employees participation in a national medical plan. You can also select no coverage if you have coverage elsewhere or are a part-time employee. For purposes of this summary plan description, the following terms shall have the following meanings: "Company" means Liberty Mutual Group Inc.; "Participating Employers" means the Company and its subsidiaries that participate in the Medical Plan. A listing of Participating Employers is available in the Benefits section of the Employee Center on the Liberty Mutual Intranet.

A Self-Insured Plan

The Liberty Mutual Medical Plan is a "self-insured" plan. This means that health care claims are paid from the Company's general assets. The money used to pay the claims comes from your contributions for coverage and the Company's contributions. *Please note: The only exception is for employees who reside in Hawaii. As a result of state mandates, the benefit*

design differs and the plan option offered to Hawaii residents is a fully insured plan through Blue Cross Blue Shield of Hawaii.

Plan Design

The Medical Plan offers employees and eligible dependents a national network preferred provider option (PPO) plan with in-network and out-of-network coverage, depending on whether or not a network provider is used. Covered employees may choose to receive services from either in-network or out-of-network providers. The claims administrators for the provider networks don't provide health care insurance – they process the claims and manage the health care provider networks. Depending on the state in which you reside, your administrator is Aetna or Blue Cross Blue Shield of Massachusetts. In the states of New York and Pennsylvania, your home zip code determines whether your administrator is Aetna or Blue Cross Blue Shield. Prescription drug benefits are a component of the Medical Plan and are administered by Medco. If you live in Hawaii, your administrator is Blue Cross Blue Shield of Hawaii, and prescription drug benefits are administered by Blue Cross Blue Shield of Hawaii.

In the Aetna-administered network, preferred providers are part of the "Aetna Choice POS II" network. In the Blue Cross Blue Shield-administered network, preferred providers are part of the "Blue Care Elect Preferred Provider Organization (PPO)" network.

Under the Medical Plan there is in-network coverage and out-of-network coverage – depending on whether you choose to use a preferred provider who is in the network, or an out-of-network provider. This refers to the "network" of health care providers (including physicians, Specialists, and hospitals) that have contracted to provide quality services in a cost-effective manner. When you receive in-network care from a preferred provider, your out-of-pocket expenses are generally lower (for example, 90% or 80% coinsurance vs. 70% coinsurance).

The Medical Plan also has annual deductibles and out-of-pocket maximums. All services have [B-5] coinsurance, with the amount depending on whether you receive care from a preferred or a non-preferred provider and whether you see a Primary Care Physician or a Specialist for an office visit. The only exception is in-network Preventive Care coverage, which is covered at 100% (see page B-46). Your Base Pay determines your annual deductible and out-of-pocket maximum (see page B-21 for details).

A directory of providers who participate in each of the claims administrators' networks is available through the *myLiberty Benefits* web site, or by calling the claims administrator. Medical Plan coverage and provisions are explained in further detail in this summary plan description. The toll-free Member Services telephone number for your claims administrator can be found on your identification card, or on the *myLiberty Benefits* web site. Contact information can also be found at the end of this document.

No Coverage

You may also waive medical coverage. Unless you are a part-time employee, in order to waive coverage, as a condition of your employment, you must certify that you have coverage elsewhere at the time you make your election to waive medical coverage under the Medical Plan.

Note: All full and part-time employees who reside and/or work in the state of Massachusetts are required by state law to provide certification of coverage elsewhere if electing to waive coverage under the Medical Plan when first eligible and annually thereafter during Annual Enrollment. In the case of an election to waive coverage, if you do not submit a medical coverage waiver form to the HR Support Center within 30 days of your coverage effective date, you will "default" to Employee Only coverage in the Medical Plan. The default coverage will remain in effect unless a Medical waiver of coverage form is received by the HR Support Center within 30 days of the election date. After your waiver certification is processed, you will be reimbursed for deductions taken during the default coverage period.

General Provisions and Self-Insured Only Provisions

This summary plan description contains general information that applies to both the self-insured plan and the fully insured option in Hawaii. Pages B-4 to B-11 and B-51 to B-75 apply to both the self-insured

plan and the Hawaii option. Pages B-12 to B-51 describes the benefits of those participants enrolled in the self-insured plan.

Eligibility

You become eligible for coverage on your date of employment if you are on the U.S. payroll and are a regular full-time employee, or a regular part-time employee, scheduled and regularly working 20 hours or more per week. Individuals classified as independent contractors or leased employees are not eligible for coverage, even if they are later reclassified as common law employees for tax purposes.

Eligible Dependents

As an eligible employee, you may also choose to enroll your eligible dependents for coverage. Eligible dependents include:

- your legally married spouse; and
- your child (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) under age 26, unless he/she is an adult child (that is, a child age 19 and older) who is eligible for his/her own employer-based health care coverage.

* * *

[B-28] mother, discharge the mother or her newborn earlier than 48 hours (or 96 hours

as applicable). If the hospital stay is required to extend beyond the time mentioned above, the provider or member must call to get additional days authorized.

- **For all non-emergency hospitalizations**, your claims administrator must be contacted at least seven calendar days prior to admission. Your claims administrator may require earlier notification, so you should check with your claims administrator as soon as your hospitalization is scheduled.
- **For emergency hospitalizations**, your claims administrator must be contacted within 48 hours of the emergency admission.

Well-Baby Programs

The Medical Plan provides screening for risk factors in pregnancy, patient information, and case management. Contact your claims administrator as soon as your pregnancy is confirmed for additional information.

Your claims administrator then sends you educational information, sometimes accompanied by a questionnaire designed to help identify potentially high-risk circumstances. Your doctor may also be contacted to help screen for any factors that might put you at risk for complications. If further assistance is appropriate, a nurse works with you on a regular basis to help you and your doctor with any special medical needs. The program's goal is to assist women in getting the care

they need, especially in the important area of prenatal care. All information is kept strictly confidential.

Emergency Situations

In life-threatening emergency situations (e.g., severe chest pains, prolonged bleeding, broken bones, etc.) seek medical care immediately. First you pay the $100 charge for use of the emergency room, then charges for services received from a preferred or non-preferred provider are paid at 90% (80% if a Specialist) after the in-network deductible is met. The $100 charge is deducted from the total charges prior to applying the applicable deductible and/or coinsurance and does not apply to the annual deductible or out-of-pocket maximum. The $100 charge is waived if you are admitted.

Definitions

A masculine personal pronoun includes the feminine where the context requires.

"Accidental injury" or **"injury"** means bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

"Active employee" means an employee of a Participating Employer who works regularly. The employee may work at any of the Participating Employer's business locations. He may also work at any other location where the Participating Employer's business requires him to travel.

"Ambulatory surgical center" (or freestanding emergency center) means a facility that:

(a) is established, equipped and operated mainly to perform surgical procedures;

(b) is operated under the supervision of a staff of physicians and provides the full-time services of at least one RN;

(c) is licensed by the jurisdiction in which it is located;

* * *

[B-46] **Personalized Medicine Program**

The Program, which is voluntary, centers on advances in personalized medicine (pharmacogenomics) and offers the opportunity to use genetic testing to determine the appropriate dosage or effectiveness of a specific drug. By determining which drugs and dosages will work best for an individual, medication therapy can be safer and more effective. Currently, the Program focuses on improving therapies for warfarin (sold under the brand name Coumadin), tamoxifen, Plavix® and medications that treat certain types of cancer as well as HIV/AIDS.

Services for the Program may include:

- Identifying retail and mail pharmacy claims for warfarin or tamoxifen
- Contacting the physician first for approval to contact a patient to discuss availability of testing

- Contacting patient to discuss the program and to obtain knowing and voluntary consent
- Providing test kit to patients
- Processing the test and providing results to the physician and the Medco pharmacist
- Contacting the physician to discuss test results

The completely voluntary and confidential test, offered to you at no cost, allows you and your physician to determine whether any changes in your drug therapy may be beneficial.

Preventive Care

Benefits for Children through Age 18

A baby is covered as a dependent from the date of birth, provided that dependent coverage is in force at that time, or is added, as a Status Change, within 60 days of the birth. This includes coverage for hospital charges for routine nursery care during the mother's hospital confinement, physician's charges for circumcision, and the initial in-hospital physician's visit.

Benefits are provided for in-network outpatient preventive care services from the date of birth through 18 years of age, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment at the following intervals:

- six times during the child's first year after birth,

- three times during the next year,
- annually thereafter, through age 18. (Note: Out-of-network care is limited up to age 6)

These services shall also include hereditary and metabolic screening at birth, appropriate immunizations (only when an in-network provider is used) and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician. The services are covered at 100% without an annual deductible if a preferred provider is used. If an out-of-network provider is used, the out-of-network benefits level applies. All other applicable provisions, limitations, exclusions and exceptions of the Medical Plan also apply.

Coverage For Health Examinations (Age 19 and Older)

Under the in-network level of benefits, members may receive an annual health assessment from an in-network (or preferred) provider, limited to one visit per calendar year, with services covered at 100% without an annual deductible. Routine immunizations, tests, and lab fees administered as preventive services during the health assessment are included.

Annual Flu Prevention

Under the in-network preventive services benefits, members may receive an annual flu shot from an

Vermont Frequently Asked Questions (FAQs) for the Collection of Commercial Claims Data

1. *Vermont has an October 31, 2008 due date for historical production files for monthly and quarterly submitters. What is the timeline for deliverables and testing between now and then?*
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10. *What lines of business are to be included?*
11. *Why do some of the coded values differ across file types? Why do some code values not have a value to represent unknown?*
12. *What provisions are in place to ensure data confidentiality, particularly with regard to sensitive diagnosis (HIV/AIDS) and procedures (abortion)?*
13. *If certain fields are unavailable when we submit data, but later become available will we need to resubmit everything?*

14. *Our membership eligibility data is based on a start and end month. Can we report it to the MHDPC in that manner?*

15. *If the coverage level code of a member changes during the month, which coverage level code do you want – the first, the last or all of them in a given month?*

16. *Our internal coded values differ from the regulation and do not directly map, what do we do?*

17. *Do we include a member identifier in the plan specific contract number field (ME009, MC008, PC008)?*

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19. *In our system we do not use a version number to identify adjustments. What do we do?*

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23. *We sell products across state borders in New England and therefore have members that may have changed state residence over time. We only keep the latest subscriber address for a given subscriber and their dependents. Therefore, if a member living in New Hampshire in November 2007 moves to Vermont in December 2007 and we pay claims for that member in December 2007*

with an incurred date in November 2007 or prior what do we do with these claims?

24. *What is meant by the Insured Group or Policy Number (ME006, MC006, PC006)?*
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38. *For the Facility Type field (MC037), we cannot distinguish ambulance land (41) from ambulance – air or water (42). How should we code our ambulance claims?*

39. *How are new codes authorized by CMS but not included in the regulation to be reported?*

40. *Should students be reported in the eligibility and claims data?*

41. *How do we report a student in the Individual Relationship Code (ME012, MC011, PC011) field?*

42. *How do we report a disabled dependent in the eligibility field Individual Relationship Code (ME012)?*

43. *What is the relationship between medical claims fields Type of Bill (MC036) and Facility Type (MC037)?*

44. *For the medical claims field Facility Type, we cannot distinguish Residential Substance Abuse Treatment Facility (55) from Psychiatric Residential Treatment Center (56). How should we handle this?*

45. *Is it acceptable to have different versions of the city name (ME015, MC014, MC033, PC014, PC022) such as East Royalton, E Royalton for the same zip code (ME017, MC016, MC035, PC016, PC024)?*

46. *We do not collect country (MC072) for our providers. How should we report this?*

47. *We pay a lot of case rate and/or global rates on certain types of claims, how are they to be reported?*

48. *I was just notified that my file failed, how long do I have to address the issues?*

49. *Is Medicare Part C and D required in this data collection?*

50. *If a member is terminated on the second day of the month and has no claims, should s/he still be included?*

51. *For diagnosis code fields, we have values like V73.88. Are they expecting V73 or V74 or V7388 in the extract file?*

52. *Should the eligibility records of non-Vermont residents who received covered services provided by Vermont health care providers or facilities be included or excluded? If non-Vermont residents are to be included, which month's eligibility records would be expected – the eligibility for the same month as the paid claims?*

53. *My understanding is that the insurance carrier is responsible to provide the data that we provide to them, therefore, we (the Third Party Administrator) do not report directly to you.*

54. *The header record for each file contains a comments field, HD008. Can this field be left empty?*

55. *Please confirm it is okay to put '0' (which translates to N/A) in the ME031 Special Coverage field as we are not familiar with the other values listed.*

1. **Vermont has an October 31, 2008 due date for historical production files for monthly and quarterly submitters. What is the timeline for deliverables and testing between now and then?**
   Since the contract signing in early2008, MHDPC has been working on the necessary updates to the system to accommodate testing of carrier files. The system will be available to receive test data on October 14, 2008. The detailed timeline for testing and submission of the historical data is part of the statistical plan and includes the registration of carriers, assignment of carrier IDs and notification back to the carriers, carrier level encryption testing and necessary receipt of certain coded data element definitions (i.e., provider specialty codes and if necessary "Home Grown" or local procedure or diagnosis codes).

2. **Is there a plan to allow for technical questions in the future?**
   MHDPC staff is available to answer questions via email, conference call or face-to-face meeting. At any point a carrier can contact MHDPC with technical and/or compliance questions by sending an email to VTinfo@ncdms.org A MHDPC staff member will respond and arrange for the appropriate follow up. In addition to one-on-one communication, a quarterly newsletter will be created to inform all carriers of general technical and compliance status and other topics of interest. Newsletters will be distributed via email and posted on the web site.

3. **What is the timeline and content of the statistical plan?**
The statistical plan as approved by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) will be released to all identified carriers and interested parties and posted on the web site. The statistical plan includes:
Data encryption description;
System start up time line;
Data collection regulation;
Data submission instructions including submission time line and submission formats;
Instructions for testing data and submitting historical data; and
Data quality standards including data element loading and data quality editing thresholds.

4. **Are denied claims required to be submitted?**
In general denied claims are not to be submitted in any of the claims extracts. However, there are issues that complicate this general regulation. There are primarily two types of denied claims:

a. Where the entire encounter with a provider is denied (e.g., the encounter before or after a member's coverage period, the service was not a covered benefit under the member's benefit structure)

b. Some but not all of the service lines are not covered within a claim (e.g., the service line for a surgical tray is denied because it is included as part of the payments made for the surgery procedure line itself). In the

examples above, the claims for encounters that are totally denied will be excluded and claims with mixed covered and non-covered services will include only the service lines for the covered services.

If a carrier processes global claims (e.g., a particular surgery for a hospital is paid under a global fee regardless of the member's complications and/or length of stay resulting in only the first line of the claim containing any paid dollars and all other detail service lines are "denied"), all of the claim lines in the global claim should be submitted to the MHDPC.

If a carrier has no responsibility/liability for a service that was rendered under the member's benefit structure then the claim/claim lines should be excluded. If the carrier has responsibility to cover a particular rendered service, but some covered services appear to be denied because of processing and payment structures in place then those claims/claim lines should be included in the extract.

5. **How should prescription drug services rendered within a medical claim be represented?**

Any prescription drug services that are rendered as part of the medical claim should be included in the medical claim file and be represented using an appropriate revenue code (MC054) and/or J-code reported in the CPT field (MC055). It is understood that for prescription drug claims identified through a revenue code will not have an associated NDC code to indicate the specific

drug dispensed. Also, it is understood that these claims/claim lines will not be present in the prescription drug claims.

6. **What is my submitter code?**
The MHDPC submitter codes, also known as the payer code, payer ID, carrier ID, etc., will be assigned and sent to you once your organization has registered with the MHDPC. For BISHCA the format of a submitter code will be a 7 or 8 character value with the first two characters being 'VT' – state code, the third character is a value of either 'C' or 'T' or 'G' where C represents a commercial insurer, T represents a TPA and G represents a government payer like Medicaid or Medicare. The next four characters will be an assigned number with the 8th position reserved for a suffix to distinguish reporting systems within a carrier.

7. **Is there a method to submit late claims paid during a prior submission period?**
Yes there is; however, the MHDPC wants to limit these types of submissions to a minimum as it complicates transferring data to the State. Basically, if a carrier identifies to the MHDPC a block of data that should have been included in a monthly paid data submission that has already been accepted by the MHDPC but for one reason or another it was omitted, then the MHDPC will issue a temporary submitter code with a new suffix to that carrier. The carrier will use this temporary code to submit the previously paid data and the MHDPC has a process in place that once this special data submission has been accepted the data will be migrated to the proper submitter

code. If a carrier's original submitted file has yet to be accepted by the MHDPC then the carrier will be requested to re-submit both the data from the original data submission and any new data identified in one file. Also please read the FAQ on how do I determine what should be included.

8. **How do I determine what data should be included in a monthly claims file?**
The monthly submission of claims data from a carrier to the MHDPC is termed a "Paid Claims Dataset". To verify that the data is [sic] a submission is being accurately selected the MHDPC uses the Header record begin and end dates formatted as YYYYMM and in each detail record we use fields – Medical MC017 & Pharmacy PC017 – Date Service Approved (AP Date). The MHDPC verifies that each date supplied in fields MC017 and PC017 are between the header records begin and end date timeframe. For a single month submission the header record would contain the same value in both begin and end date fields. Now, what data field should be used to populate fields MC017 and PC017? There are a number of potential values that could be used to populate these fields, but whatever value is used needs to be consistent within a carrier from month to month, otherwise we run into problems with either missing claims for a certain time period or receiving duplicate claims for a certain time period. As a basic regulation the date field that should be used to populate these two data elements is the date field that is used by the carriers extract program to determine what data should be included in a given months data submission. That means that is the true paid date is

used to select records for inclusion in a file than the paid date values should be placed in these fields, but if a data warehouse update/load date is used to select records for a data submission then that date value should be used to update these data elements. We have found through working with carriers submitting data for Maine and New Hampshire that any of the following fields could be employed for selection and inclusion of data: Claim Paid Date, Claim Accounts Payable Date, Check Cut Date or Warehouse Update/Load Date, but in any case once a method has been selected by a carrier we do not want the carrier to later change the value that they are using.

9. **Should vision claims be included?**
If the vision service is a covered medical benefit (e.g., the member over 18 who can receive one eye exam at a participating eye care specialist once every two years) it must be submitted as a medical claim. Unless it is a covered medical benefit, MHDPC should not receive any claims for eye care products, such as prescription eyeglasses, contacts, solution, etc. Any prescriptions covered under a member's prescription drug benefit would be included in the pharmacy claim submission.

10. **What lines of health insurance business are included and excluded?**
Please refer to Vermont *Regulation H-2008-01*, Sections 4 and 5 to identify the lines of health insurance included in the claims reporting mandate and also what is excluded.

11. **Why do some of the coded values differ across file types? Why do some code values not have a value to represent unknown?**
Although the HIPAA standard coding schema was adopted for the coding structure within the Vermont claims regulation, the HIPAA electronic transmission coding standards are not standard across the different file types. Therefore, the prescription drug specifications call for gender codes of 1, 2 or 3 while the medical and eligibility specifications require a gender code of M, F or U. This follows the HIPAA requirements for these data sets. Please use caution when setting up your extract to code all of these fields appropriately. Similarly, if a coded field does not have a value to indicate "unknown" it is because HIPAA did not allow for an unknown value to be reported. In a few instances only a subset of the HIPAA codes are allowed in the extract. This was done to restrict the use of non-specific codes.

12. **What provisions are in place to ensure data confidentiality and protection of potentially sensitive information?**
Through the use of the encryption software all direct PHI data elements are encrypted through a one-way hashing function before they leave the carrier so the VHCURES files do not contain direct patient or member identifiers. Under Vermont regulation H-2008-01, provisions addressing the release and use of VHCURES data are found in Section 8 in: http://www.bishca.state.vt.us/HcaDiv/RegsBulls/hcaregs/REG_H-2008-01.pdf

13. **If certain fields are unavailable when we submit data, but later become available will we need to resubmit everything?**
The data layouts currently accommodate all known required data elements. A carrier must provide all required data elements appropriate for the data set and the time period at the time of submission. Completeness thresholds have been established for each data element and are documented in the statistical plan. Submissions with data elements failing the completeness threshold for one or more fields will be rejected in their entirety. A carrier unable to meet the completeness. A carrier unable to meet the completeness threshold due to restrictions within their system will be referred to BISHCA for a decision on how to proceed.

14. **Our membership eligibility data is based on a start and end month. Can we report it to the MHDPC in that manner?**
No. The eligibility data is submitted in a monthly format with one record for each covered life eligible for one or more days of services during the reported month. Each eligibility record in a given month's file will represent one active member with all reported data elements representing either the status as of the end of the reporting month or as of the premium billing date. For the required historical data feeds carriers will submit one record per member per month of active coverage during the 15 month period. For the historical data, MHDPC is requiring that each month of eligibility data be submitted in a separate monthly file.

15. **If the coverage level code of a member changes during the month, which coverage level code do you want – the first, the last or all of them in a given month?**
The status code for the coverage level field in the eligibility file should be as of the end of the month or the applicable code for when the premiums were billed for that member during the month. This same regulation applies for all the other data elements in the membership file, such as the employer group/policy number, member zip code, etc. In all cases, only one value should be reported in a membership record and only one membership record should exist for a member each month.

16. **Our internal coded values differ from the regulation and do not directly map, what do we do?**
Any internal carrier coded values that do not directly map to coded data element values within the regulation will need to be evaluated on a field-by-field basis. Please email us at VTinfo@ncdms.org and list the regulation data element field number in question as well as the values and descriptions that you have available to map. We will work with you to assign the values as accurately as possible.

17. **Do we include a member identifier in the plan specific contract number field (ME009, MC008, PC008)?**
No. It is common for a carrier to have a member identifier or sequence number attached to the end of the subscriber contract number sometimes separated with an asterisk (*) or other value. The

combination of these two values represents the member's full identification number. In this situation, the regulation calls for you to submit the plan specific contract number that would be used to identify all members of a family (subscriber and dependents). The sequence number should be placed in the member sequence number field (ME010, MC009, PC009) and the asterisk or other delimiter is ignored.

18. **We cannot break our provider name information into separate fields, is this acceptable?**
When the provider name CANNOT be separated into first name, last name, middle name and suffix data elements, then the entire provider name should appear in the "Service Provider Last Name/Organization Name" field. This should only be done as a last resort.

19. **In our system we do not use a version number to identify adjustments. What do we do?**
If a carrier's processing system or data warehouse does not use a record versioning method to identify adjustment records for a claim, then the version number field should be defaulted to a value of 0. This will be acceptable as long as any reversal and/or adjustment records are reported in such a way that a given claim line can have all of its versions identified and consolidated together so that the result is one claim line for an incurred service processed over a given paid date range with the correctly summarized dollar values. As part of the follow up to the carrier registration, we will be asking the carrier to explain in English terms and examples how BISHCA would

take the carrier's submitted paid dataset and convert the claim lines into an incurred dataset for a given paid date range resulting in correctly summarized dollars. This information will be passed on to BISHCA.

20. How should we report multiple E-Codes on a claim?

If a given claim contains multiple E-Code values in the diagnosis fields then the first E-Code encountered in the processing of the claim should be loaded into the E-Code data field (MC040) in the extract submission. All other E-Codes in other diagnosis fields should be listed in the Other Diagnosis code fields (MC042-MC053) after all other regular ICD-9 diagnosis codes have been listed. An E-Code should never be listed in the primary diagnosis data field (MC041).

21. How should we report multiple revenue codes or procedure codes listed on a single claim line?

The MHDPC is acquiring examples of how this can happen. We do understand that on a hospital/facility claim a given claim line may have both a revenue code and a Procedure/CPT code. In that instance the revenue code is reported in MC054 and the CPT code is reported in MC055. It is unclear how a single claim line can have multiple CPT codes or multiple revenue center codes assigned to it unless one code is the original billed code and one is the modified payment code based on contracting changes made by the carrier. If the later is true MHDPC staff will work with you to arrive at a solution.

22. **Should text fields be padded with blanks and should numeric fields be padded with zeros to their maximum length?**
No padding should occur. Although the record layouts list a maximum length that will be accepted, the submission is designed to be variable length. No text field should be blank or space padded on either the right or left and the numeric fields should not be zero padded to the left of a value. If this is done, it can cause your transfer rate to slow down. Even though the file to be transmitted is compressed, there is still space used to represent the blanks, spaces and zeros and, in a large data file, this additional space could be substantial enough to lengthen the transfer time. Also, if the fields to be encrypted have been blank/space padded then the encryption routine may fail (if the whole field is blank) or may not properly encrypt the value.

23. **We sell products across state borders in New England and therefore have members that may have changed state residence over time. We only keep the latest subscriber address for a given subscriber and their dependents. Therefore, if a member living in New Hampshire in November 2007 moves to Vermont in December 2007 and we pay claims for that member in December 2007 with an incurred date in November 2007 or prior what do we do with these claims?**
We recognize that this issue exists. We would want to see those claims submitted rather than put the burden of eliminating those claims from the file on a carrier. This policy will result in claims records with no supporting eligibility

records in our database for November 2007 We will evaluate the prevalence of claims unsupported by eligibility data on an ongoing basis and determine if they should be dropped from the database at a later date. The MHDPC feels this is the best current solution rather than ask you, the carrier, to try and determine if and when the address of a subscriber changed from one state to another.

24. What is meant by the Insured Group or Policy Number (ME006, MC006, PC006)?

The Insured Group and/or Policy Number is the employer group or account number(s) for the contracted employer. There may be one or more of these numbers for a given employer group according to how your system is set up. Furthermore, if your plan writes individual policies, this number would be the actual policy number unless your system uses the subscriber's identification/contract number for an individual policy number. In that situation, the individual's insured group or policy number should be reported as "INDIVIDUAL".

25. What about payer-specific provider specialty codes, procedure codes, and diagnosis codes?

There is a provision in the regulation to have all carriers submit a spreadsheet of all carrier assigned provider specialty codes with their descriptions. The spreadsheet should contain the provider specialty code and a definition of the code. MHDPC also requires a spreadsheet that contains any home grown or local procedure or diagnosis codes with their corresponding descriptions.

Failure to provide the local codes could cause your medical claims submissions to fail for the inclusion of procedure and diagnosis codes that are not recognized by the system.

26. How do the Data Load and Data Quality Edit thresholds work?

Based upon the review of existing claims databases, standards have been established for the quality of the data to be submitted. In the data load, each data element has been assigned a minimum percent completeness threshold. In general the data element's completeness is evaluated by the total number of valid entries divided by the total number of records submitted. However, for some data elements, the denominator is a subset of the data because of the nature of the data element. The specifications for calculating each data element's threshold and the statewide number for that data element are documented in the statistical plan. Failure of a submission to meet one or more of the completeness thresholds will result in the automatic failure of the submission.

Similarly, the data quality edits are designed to evaluate the content of the data submitted and frequently involves the comparison of two or more data elements. The data quality thresholds represent the maximum tolerance for data issues. The data quality specifications and the tolerance thresholds are documented in the statistical plan. Failure of a submission to stay below one or more of the data quality edits will result in the failure of the submission.

It is understood that system restrictions may prevent a carrier from meeting all of the data tests. In those situations, MHDPC will work with the carrier to document the source of the problems to present to BISHCA for a temporary or permanent exemption. All such deviations from the statewide quality standards must be approved by BISHCA. .

27. **Are we to include the procedure code (MC055) as it was submitted or as it was paid?**
If you have the ability to re-code CPTs based on claims processing and standard CPT coding logic, then the CPT included in the file should be the CPT tied to the actual payment dollar amount.
Medical file example:
MC055 – CPT Code of procedure as paid
MC062 – $ amount of submitted procedure (billed charges)
MC063 – $ amount of paid procedure

In this example the CPT codes for the dollar amounts listed in MC062 and MC063 could be different and the actual CPT code that is submitted would be the one tied to the dollar amount listed in MC063.

28. **In the pharmacy file layout you are asking for the charge amount. Our system does not have that value. What should we do?**
The amount/value of this data element should represent the fully loaded cost/charge of the pharmaceutical dispensed. It should contain at least the Ingredient Cost/Billed Amount (PC037),

the Dispensing Fee (PC039), any administrative fee and any applicable tax.

29. **There are two things that you can do to make the transfer as secure as possible:**

    a. Use the SSL certificate to insure that the web site you are connecting to is, in act, the web site that you are supposed to be connecting to. When connecting to the secure portion of the NCDMS web site (user services including encryption utility software download, data file upload, and data submission reports), you should see an icon of a locked golden padlock along the bottom of your browser window. By clicking on this icon, the certificate can be viewed. You should examine the certificate and make sure that the certified network address, organization name, and organization location are what they should be (secure.mhic.org, Maine Health Information Center Inc, Manchester, Maine, US) and that the certificate date range is valid. If this information is not valid, or if you see the icon of an unlocked golden padlock along the bottom of your browser window, you should contact us before proceeding.

    b. Use the highest supported level of encryption when transmitting data to us. There are two levels of encryption that are supported by the SSL standard (50-bit and 128-bit). Some web browsers support only the lower level of encryption (50-bit). Our web server supports higher level 128-bit encryption but will negotiate with the web browser that is asking for

a connection and will drop down to the lower level 50-bit encryption if that is all that your browser can support. The 128-bit encryption is significantly harder to crack than the 50-bit and if you are concerned about security, you should make sure that the browser you are using supports 128-bit encryption. You can check this by clicking on the help option in Internet Explorer and going to the "about Internet Explorer" drop-down menu option. On the pop-up screen, there will be an entry titled "cipher strength" which will say either 50-bit or 128-bit. If your browser is using 50-bit encryption, you can download the 128-bit version of Internet Explorer at no cost from Microsoft.

30. **What is the transmission time frame for the data?** In general, data must be filed by the last day of the month for the previous month's activity. Therefore, on April 30, 2009, data for March 2009 must be submitted. Mandated reporters with 2,000 or more covered Vermont lives must submit monthly and begin submitting in October 2008 for the period of January 2007 thru September 2008. Mandated reporters with 500-1,999 covered Vermont lives will start submitting data in October 2008 for the period of January 2007 thru September 2008 and assume a quarterly submission schedule after the historical data is in. Mandated reporters with 200-499 covered Vermont lives will begin submitting in October 2008 for the period of January 2007 thru December 2007 and assume an annual submission schedule after the historical data is in.

31. **Whom do I contact if I am having upload problems?**
    For general transmission, technical or data questions or for web upload questions please contact VTinfo@ncdms.org and your question will be routed to an appropriate staff member for a response.

32. **Do we have to use the asterisk (*) as the field separator in the files? What if a text value contains an (*) within it?**
    The use of the asterisk (*) as the field separator is a HIPAA standard and a regulation specification requirement and MUST be used to separate each field within the required files. Although, not specifically stated in the regulation, it is perfectly valid to enclose any or all text/alpha fields within double quotes – ex: "abc". If a text value that is required actually contains an (*) as one of the characters then that field MUST have double quotes around the entire value – ex: "ab*cd". It is not acceptable to have a double quote embedded in any text value. If double quotes exist in your incoming data (generally found in Drug Name (PC027)) they must be removed prior to submission of the data.

33. **There is something wrong with the encryption software. I can't get it to work. What should I do?**
    a. Download the sample data files from the web site and run those through the encryption software. If this does not work, email us at VTinfo@ncdms.org

b. Check your data for imbedded asterisks in the data values. These must be enclosed in double quotes.

c. If the above do not correct the problem, email us at VTinfo@ncdms.org.

34. How are Type of Bill – MC036 and Facility Type – MC037 related?

These two data elements are mutually exclusive. Type of Bill (MC036) should only be available for hospital/facility claims (claims from the UB 92/04 forms or 837 HIPAA facility transaction set) and facility type (MC037) should only be available for professional claims (claims from the HCFA-1500 forms or 837 HIPAA Professional Transaction set). NCDMS looks for the combination of these two fields to be filled in 100% of the time and are critical data elements for the system's determination of denominator values to perform Load and DQ edit threshold checks.

35. How will I find out if my submission failed?

All registered contacts for a carrier will receive emails from NCDMS for submissions automatically failed by the system. The email will briefly explain the reason for the failure. The details of problems associated with the data can be viewed by logging on to the system and looking at the system entries associated with that submission. Emails may also be sent by MHDPC staff to the contacts for data quality issues. These emails are customized and contain specific information about the problems identified. An email initiated by MHDPC staff often results in opening a dialogue between the carrier and the MHDPC staff.

36. Will MHDPC be signing confidentiality agreements with the individual plans and data submitters?

MHDPC will not be signing agreements with the individual submitters. The Department of Banking, Insurance, Securities and Health Care Administration of Vermont has the statutory authority to compel the collection of this data and will serve as the agency responsible for safeguarding its contents and use. Since MHDPC is functioning as an agent of BISHCA, no signed agreements are required.

37. What are the most common mistakes made when submitting data?

Any of the following can cause the submission to be rejected.

a. **Wrong relationship code (ME012, MC011, PC011).** HIPAA standards call for different code values for eligibility data vs. claims data. For example, the employee is coded as 20 in MC011 and as 18 in ME012.

b. **Wrong product code (ME003, MC003, PC003).** HIPAA standards call for different code values for eligibility data vs. claims data. For example, indemnity insurance is coded as IN in ME003 and as 15 in MC003.

c. **Low paid to charge ratio in claims data (MC063 : MC062).** This is generally because the payer has failed to code the product as Medicare (MC003 = MA, MB) or failed to code the claim status as secondary (MC038 = 02).

d. **Claims unsupported by eligibility data.** In general over 95% of the claims incurred for a given month should be supported by eligibility data submitted for that same month. This does not happen when the member identifiers are not reported exactly the same way in the eligibility file and in the claims file.

e. **Invalid and missing procedure codes.** If a payer accepts local CPT codes and does not provide those codes and their associated descriptions to the MHDPC, records with those local codes will be flagged as in error. If the payer makes payments directly to members and there is no procedure code information, a dummy code must be entered in the CPT Field (MC055). We recommend a code of MBR. If the plan pays for prescription drugs through the medical plan and no NDC code or J-Code or revenue code is available, a dummy code must be entered in the CPT Field (MC055). We recommend a code of DRUGS. If you use codes other than those recommended, you must report those to us.

f. **Invalid diagnosis codes.** Payers must report all valid characters of the ICD-9 diagnosis code. Some payers collect only the first 3 characters. This will cause the submission to fail. Decimal points must not be included in the reported diagnosis code.

g. **Too many members associated with a single contract.** This is generally an eligibility file problem caused by reporting the group or policy number in the contract field

(ME009). When populated, ME009 should be unique for the subscriber. This field must not be submitted with all 9's, 0's, etc. If the subscriber's social security number is provided, this field can be blank.

h. **Average age over 65.** It is highly suspicious to see a submission with an average age over 65 and the product code not set to Medicare. Such a submission will fail until corroborated or corrected by the carrier.

i. **Missing provider information.** Provider information is required for all medical claims. If payments are made to the member, an entry still must be made in the provider last name field (MC030), the provider specialty field (MC032) and in the service provider number field (MC024). All records must have a service provider number, service provider name and a service provider tax ID. Failure to provide this information will cause the submission to fail.

j. **Mixed signs in a single record.** Positive dollar amounts are not to be preceded by a + sign. We expect all adjustment records with negative dollars amounts will have all dollar fields as well as the quantity or unit fields coded as negative. If your system adjudicates claims in such a way that a line item may have both negative and positive records, you will need to explain this to us or the submission may fail.

k. **Dates out of range.** The HDR and TRL records specify the earliest and latest dates

submitted in the file. For eligibility data this relates to year and month (ME004, ME005), for medical claims date service approved (MC017) and for pharmacy claims date service approved (PC017). A submission with one or more records outside the date range on the HDR and TRL records will be rejected.

l. **Invalid file format.** A file submitted with the wrong number of data elements (too few or too many) for the data type will be rejected. A file submitted with alpha data in a numeric field will be rejected.

38. For the Facility Type field (MC037), we cannot distinguish ambulance land (41) from ambulance – air or water (42). How should we code our ambulance claims?
Code them as ambulance – land (41)

39. How are new codes authorized by CMS but not included in the regulation to be reported?
Any valid CMS codes may be reported for a data field. Please contact vtdata@ncdms.org with new values you intend to use before submitting the data. This will allow us to add the values to our reference tables to prevent your submission from failing.

40. Should students be reported in the eligibility and claims data?
Yes, if they are permanent residents of Vermont or they have had services provided by a Vermont provider.

41. **How do we report a student in the Individual Relationship Code (ME012, MC011, PC011) field?**
Students should be coded as 19 – Child. We recognize that students can be as old as 26.

42. **How do we report a disabled dependent in the eligibility field Individual Relationship Code (ME012)?**
If the dependent is < 18, code the member as 19 – Child. If the dependent is > 18, code the member as 34 – Other Adult.

43. **What is the relationship between medical claims fields Type of Bill (MC036) and Facility Type (MC037)?**
These fields are not mutually exclusive. Type of Bill (MC036) should only be populated on UB facility claims and Facility Type (MC037) must be populated on professional claims. Facility Type (MC037) may also be reported for facility claims.

44. **For the medical claims field Facility Type, we cannot distinguish Residential Substance Abuse Treatment Facility (55) from Psychiatric Residential Treatment Center (56). How should we handle this?**
Use the diagnosis codes to distinguish between the two codes. If a patient has both a substance abuse diagnosis and a psychiatric abuse diagnosis on the claim, code the claim according to whichever of those appears first.

45. **Is it acceptable to have different versions of the city name (ME015, MC014, MC033, PC014, PC022) such as East Boston, E Boston for the same zip code (ME017, MC016, MC034, PC016, PC024)?**
Yes, that is allowed.

46. **We do not collect country (MC072) for our providers. How should we report this?**
If the provider's zip code field (MC035) contains a valid US zip code, enter US in the country (MC070) field.

47. **We pay a lot of case rate and/or global rates on certain types of claims, how are they to be reported?**
Many carriers have reported case rate or global claims with the total paid amount for the claim being reported on only one line of the claim with a claim status = 1 (paid as Primary) and all other detail claim lines are listed with an associated charge amount and no paid amount. The subsequent detail claim lines are usually listed with a claim status = 4 (denied service line). We understand that this is a function of your claims processing system. However, from a research and reporting perspective, all services rendered under this type of provider agreement are considered covered services. Therefore, it would be preferable to have all detail claim lines reported with the same claim status value as the claim line that actually contains the payment information.

48. I was just notified that my file failed, how long do I have to address the issues?

As stated in the regulation, you will have 10 business days from the time of notification that a file has failed at some point in the process. This ten-day window is a one-time period to address the identified issues in one of the following manners:

a. The identified issue is corrected and a new updated data file is submitted that shows the issue as resolved or;

b. The MHDPC and/or BISHCA staff have been contacted and an approved action plan with specific dates has been identified to resolve the outstanding issue/s. If the identified issue is corroded and new problems are introduced, the original 10 day time period is retained as the correction period. If, at the end of 10 business days, the data issue(s) have not been resolved and/or an approved action plan is not in place, the issue will be turned over to the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) for possible action.

49. Is Medicare Part C and D required in this data collection?

Yes, Medicare Part C and D members and claims are required in this data collection.

50. If a member is terminated on the second day of the month and has no claims, should s/he still be included?

Yes, all members should be reported regardless of the length of membership in the given month.

51. For diagnosis code fields, we have values like V73.88. Are they expecting V73 or V74 or V7388 in the extract file?

For diagnosis codes we would expect "V7388" for the V73.88 code.

52. Should the eligibility records of non-Vermont residents who received covered services provided by Vermont health care providers or facilities be included or excluded? If non-Vermont residents are to be included, which month's eligibility records would be expected – the eligibility for the same month as the paid claims?

Eligibility records should be included for non-Vermont residents for the month the service was provided.

53. My understanding is that the insurance carrier is responsible to provide the data that we provide to them, therefore, we (the Third Party Administrator) do not report directly to you.

Please refer to *Regulation H-2008-01* for the definition of health insurer and for entities included and excluded in the reporting mandate as described in Sections 4 and 5. The Vermont state regulation specifies that TPAs are health insurers and if they possess claims data, eligibility data, provider files and other information relating

to health care provided to Vermont residents or by Vermont health care providers and facilities they shall submit claims data if the total number of Vermont resident members served is greater than 200 or 200 non-resident members received covered services provided by Vermont providers or facilities.

54. The header record for each file contains a comments field, HD008. Can this field be left empty?

Yes, field HD008 – comment field may be left blank.

55. Please confirm it is okay to put '0' (which translates to N/A) in the ME031 Special Coverage field as we are not familiar with the other values listed.

Yes, "0" is the value you need to enter if not applicable to your company.

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Appendix B-1: Header Record Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
HD001	Record Type	1/31/2007	Text	2	HD
HD002	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
HD003	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
HD004	Type of File	1/31/2007	Text	2	DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
HD005	Period Beginning Date	1/31/2007	Integer	6	CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
HD006	Period Ending Date	1/31/2007	Integer	6	CCYYMM End of paid period for Claims End of month covered for Eligibility
HD007	Record Count	1/31/2007	Integer	10	Total number of records submitted in this file Exclude header and trailer record in count
HD008	Comments	1/31/2007	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

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Appendix B-2: Trailer Record Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
TR001	Record Type	1/31/2007	Text	2	TR
TR002	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
TR003	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
TR004	Type of File	1/31/2007	Text	2	DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
TR005	Period Beginning Date	1/31/2007	Integer	6	CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
TR006	Period Ending Date	1/31/2007	Integer	6	CCYYMM End of paid period for Claims End of month covered for Eligibility
TR007	Date Processed	1/31/2007	Date	8	CCYYMMDD Date file was created

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Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
ME002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
ME003	Insurance Type Code/Product	1/31/2007	Text	2	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Heal Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group healtl plan 14 Medicare Secondary, No-fault insurance including Auto is primary 15 Medicare Secondary Worker's Compensatic 16 Medicare Secondary Public Health Service or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Pl (LGHP) 47 Medicare Secondary, Other Liability Insurance is Primary * AP Auto Insurance Policy CP Medicare Conditionally Primary * D Disability * DB Disability Benefits EP Exclusive Provider Organization HM Health Maintenance Organization (HMO)

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Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME003 (cont'd)	Insurance Type Code/Product				HN Health Maintenance Organization (HMO) Medicare Advantage HS Special Low Income Medicare Beneficiary IN Indemnity * LC Long Term Care * LD Long Term Policy * LI Life Insurance * LT Litigation MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid MH Medigap Part A MI Medigap Part B MP Medicare Primary PC Personal Care PE Property Insurance – Personal PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary SP Supplemental Policy * WC Workers' Compensation * Indicates that code *is not* to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules.
ME004	Year	1/31/2007	Integer	4	The year for which eligibility is reported in this submission.
ME005	Month	1/31/2007	Integer	2	The month for which eligibility is reported in this submission.

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Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME006	Insured Group or Policy Number	1/31/2007	Text	30	The group or policy number – not the number that uniquely identifies the subscriber.
ME007	Coverage Level Code	1/31/2007	Text	3	Benefit coverage level CHD Children Only DEP Dependents Only ECH Employee and Children EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
ME008	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
ME009	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber' social security number.
ME010	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
ME011	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
ME012	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below 01 Spouse 18 Self/Employee 19 Child 21 Unknown 34 Other Adult

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME013	Member Gender	1/31/2007	Text	1	M Male F Female U Unknown
ME014	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
ME015	Member City Name	1/31/2007	Text	30	The city location of the member.
ME016	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
ME017	Member ZIP Code	1/31/2007	Text	11	ZIP Code of member – may include non-US codes. Do not include dash.
ME018	Medical Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC019. N No
ME019	Prescription Drug Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC018. N No
ME020	Placeholder		Text	1	Used and or proposed by other states for – Dental coverage.
ME021	Placeholder		Text	6	Used and or proposed by other states for – Race 1.
ME022	Placeholder		Text	6	Used and or proposed by other states for – Race 2.
ME023	Placeholder		Text	15	Used and or proposed by other states for – Other Race.
ME024	Placeholder		Text	1	Used and or proposed by other states for – Hispanic indicator.
ME025	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 1.
ME026	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 2.
ME027	Placeholder		Text	20	Used and or proposed by other states for – Other Ethnicity.

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Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME028	Primary Insurance Indicator	1/31/2007	Text	1	1 Yes, primary insurance 2 No, secondary or tertiary insurance
ME029	Coverage Type	1/31/2007	Text	3	ASW for self-funded plans that are administered by a third party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage ASO for self funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage STN for short-term non-renewable health insurance. UND for plans underwritten by the insurer OTH for any other plan. Insurers using this code shall obtain prior approval from BISHCA
ME030	Market Category Code	1/31/2007	Text	4	IND for policies sold and issued directly to individuals. (Non-group) FCH or policies sold and issued directly to individuals on a franchise basis. GCV for policies sold and issued directly to individuals as group conversion policies. GS1 for policies sold and issued directly to employers having exactly one employee GS2 for policies sold and issued directly to employers having between two and nine employees GS3 for policies sold and issued directly to employers having between 10 and 25 employees

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME030 (cont'd)	Market Category Code	1/31/2007	Text	4	GS4 for policies sold and issued directly to employers having between 26 and 50 employees GLG1 for policies sold and issued directly to employers having between 51 and 99 employees GLG2 for policies sold and issued directly to employers having 100 or more employees GSA for policies sold and issued directly to small employers through a qualified association trust OTH For policies sold to other types of entities Insurers using this market code shall obtain prior approval from BISHCA
ME031	Placeholder		Text	3	Used and or proposed by other states for Special Coverage. 0 N/A 1 NH HealthFirst 2 VT Catamount
ME101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
ME102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
ME103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
ME104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.

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Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
ME106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
ME899	Record Type	1/31/2007	Text	2	Value = ME

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
MC002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
MC003	Insurance Type/Product Code	1/31/2007	Text	2	12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Advantage HM Health Maintenance Organization MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid OF Other Federal Program (e.g. Black Lung) TV Title V VA Veteran Administration Plan * WC Worker's Compensation * Indicates that code *is not* to be included in Vermont submissions. Included in data set for harmonization with othe New England states' data collection rules.
MC004	Payer Claim Control Number	1/31/2007	Text	35	Must apply to the entire claim and be unique within the payer's system.
MC005	Line Counter	1/31/2007	Integer	4	The line number for this service. The line counter begins with 1 and is incremente by 1 for each additional service line of a claim.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC005A	Version Number	1/31/2007	Integer	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line.
MC006	Insured Group or Policy Number	1/31/2007	Text	30	Group or policy number – not the number that uniquely identifies the subscriber.
MC007	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as nul if unavailable.
MC008	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.
MC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
MC010	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
MC011	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC011 (cont'd)	Individual Relationship Code (cont'd)				19 Child 20 Employee/Self 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent
MC012	Member Gender	1/31/2007	Text	1	M Male F Female U Unknown
MC013	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
MC014	Member City Name	1/31/2007	Text	30	The city name of the member.
MC015	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
MC016	Member Zip Code	1/31/2007	Text	11	ZIP Code of member – may include non-US code Do not include dash.
MC017	Date Service Approved/ Accounts Payable Date/ Actual Paid Date	1/31/2007	Date		CCYYMMDD

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC018	Admission Date	1/31/2007	Date	8	Required for all inpatient claims. CCYYMMDD
MC019	Admission Hour	1/31/2007	Integer	4	Required for all inpatient claims. Time is expressed in military time – HHMM
MC020	Admission Type	1/31/2007	Integer	1	Required for all inpatient claims. Refer to Appendix A.
MC021	Admission Source	1/31/2007	Text	1	Required for all inpatient claims. Refer to Appendix A.
MC022	Discharge Hour	1/31/2007	Integer	4	Hour in military time – HHMM
MC023	Discharge Status	1/31/2007	Integer	2	Required for all inpatient claims. 01 Discharged to home or self care 02 Discharged/transferred to another short term general hospital for inpatient care 03 Discharged/transferred to skilled nursing facility (SNF) 04 Discharged/transferred to nursing facility (NF) 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution 06 Discharged/transferred to home under care of organized home health service organizatior 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC023 (cont'd)	Discharge Status (cont'd)				20 Expired 30 Still patient or expected to return for outpatient services 40 Expired at home 41 Expired in medical facility 42 Expired, place unknown 43 Discharged/transferred to a Federal Hospital 50 Hospice – home 51 Hospice – medical facility 61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed 62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital 63 Discharged/transferred to a long term care hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
MC024	Service Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. In many cases, it will be the provider Medicare number.
MC025	Service Provider Tax ID Number	1/31/2007	Text	10	Federal taxpayer's identification number.

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC026	National Service Provider ID	1/31/2007	Text	20	Required if National Provider ID is mandated for use under HIPAA. The preferred code for this element is for the rendering provider. For the billing provider, see MC077.
MC027	Service Provider Entity Type Qualifier	1/31/2007	Text	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person", and these shall be coded as a person. Insurers and health care processors shall code according to: 1 Person 2 Non-Person Entity
MC028	Service Provider First Name	1/31/2007	Text	25	Individual first name. Set to null if provider is a facility or organization
MC029	Service Provider Middle Name	1/31/2007	Text	25	Individual middle name or initial. Set to null if provider is a facility or organization
MC030	Service Provider Last Name or Organization Name	1/31/2007	Text	60	Full name of provider organization or last name of individual provider.
MC031	Service Provider Suffix	1/31/2007	Text	10	Suffix to individual name. Set to null if provider is a facility or organization The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III.), if applicable, rather than the clinician's degree (e.g., MD, LCSW).

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC032	Service Provider Specialty	1/31/2007	Text	50	As defined by payer Dictionary for specialty code values must be supplied during testing.
MC033	Service Provider City Name	1/31/2007	Text	30	City name of provider and preferably the practic location.
MC034	Service Provider State or Province	1/31/2007	Text	2	As defined by the US Postal Service.
MC035	Service Provider ZIP Code	1/31/2007	Text	11	ZIP Code of provider – may include non-US codes. Do not include dash.
MC036	Type of Bill – Institutional/ Facility Claims, such as those submitted using on UB04 forms	1/31/2007	Integer	2	Required for institutional claims. Not to be used for professional claims. **Type of Facility – First Digit** 1 Hospital 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care 7 Clinic 8 Special Facility **Bill Classification – Second Digit if First Digit = 1-6** 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC036 (cont'd)	Type of Bill – Institutional/ Facility Claims (cont'd)				5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care – Level III Nursing Facility 8 Swing Beds **Bill Classification – Second Digit if First Digit = 7** 1 Rural Health 2 Hospital Based or Independent Renal Dialysis Center 3 Free Standing Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORF) 6 Community Mental Health Center 9 Other **Bill Classification – Second Digit if First Digit = 8** 1 Hospice (Non Hospital Based) 2 Hospice (Hospital-Based) 3 Ambulatory Surgery Center 4 Free Standing Birthing Center 9 Other
MC037	Site of Service – on NSF/CMS 1500 Claims	1/31/2007	Text	2	Required for professional claims. Not to be used for institutional claims. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC037 (cont'd)	Site of Service – on NSF/CMS 1500 Claims (cont'd)				24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 35 Boarding Home 41 Ambulance – Land 42 Ambulance – Air or Water 50 Federal Qualified Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC038	Claim Status	1/31/2007	Integer	2	01 Processed as primary 02 Processed as secondary 03 Processed as tertiary 04 Denied 19 Processed as primary, forwarded to additional payer(s) 20 Processed as secondary, forwarded to additional payer(s) 21 Processed as tertiary, forwarded to additional payer(s) 22 Reversal of previous payment
MC039	Admitting Diagnosis	1/31/2007	Text	5	Required on all inpatient admission claims and encounters using the ICD-9-CM. Do not code decimal point.
MC040	E-Code	1/31/2007	Text	5	Describes an injury, poisoning or adverse effect using the ICD-9-CM. Do not include decimal point.
MC041	Principal Diagnosis	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC042	Other Diagnosis – 1	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC043	Other Diagnosis – 2	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC044	Other Diagnosis – 3	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC045	Other Diagnosis – 4	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC046	Other Diagnosis – 5	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC047	Other Diagnosis – 6	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC048	Other Diagnosis – 7	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC049	Other Diagnosis – 8	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.

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Appendix D1 Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC050	Other Diagnosis – 9	1/31/2007	Integer	5	ICD-9-CM Do not code decimal point
MC051	Other Diagnosis – 10	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point
MC052	Other Diagnosis – 11	1/31/2007	Text	5	ICD-9-CM Do not code decimal point
MC053	Other Diagnosis – 12	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point
MC054	Revenue Code	1/31/2007	Integer	4	National Uniform Billing Committee Codes Code using leading zeroes, left justified and four digits
MC055	Procedure 1 Code	1/31/2007	Text	5	Health Care Common Procedural Coding System (HCPCS) This includes the CPT codes of the American Medical Association
MC056	Procedure 1 Modifier – 1	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code When the insurer utilizes a local code system for modifier, a reference table shall be submitted.
MC057	Procedure 1 Modifier – 2	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code When the insurer utilizes a local code system for modifier, a reference table shall be submitted
MC058	ICD-9-CM Procedure Code	1/31/2007	Text	4	Primary ICD-9-CM code for this line of service Do not code decimal point
MC059	Date of Service – Form	1/31/2007	Date	8	First date of service for this service line CCYYMMDD

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC060	Date of Service – Thru	1/31/2007	Date	8	Last date of service for this service line. CCYYMMDD
MC061	Quantity	1/31/2007	Integer	3	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.
MC062	Charge Amount	1/31/2007	Decimal	10	Do not code decimal point.
MC063	Paid Amount	1/31/2007	Decimal	10	Includes any withhold amounts. Do not code decimal point. This element includes all payment made by the insurer except capitation.
MC064	Prepaid Amount	1/31/2007	Decimal	10	For capitated services – the fee for service equivalent amount. Do not code decimal point.
MC065	Co-pay Amount	1/31/2007	Decimal	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.
MC066	Coinsurance Amount	1/31/2007	Decimal	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.
MC067	Deductible Amount	1/31/2007	Decimal	10	The dollar amount of the deductible. Do not code decimal point.
MC068	Patient Account/Control Number	1/31/2007	Text	20	Number assigned by hospital.

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC069	Discharge Date	1/31/2007	Date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD
MC070	Service Provider Country Name	1/31/2007	Text	30	Code US for United States.
MC071	DRG	1/31/2007	Text	10	Insurers and health care claims processors shall code using the CMS methodology when available Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX)
MC072	DRG Version	1/31/2007	Text	2	Version number of the grouper used.
MC073	APC	1/31/2007	Text	4	Insurers and health care claim processors shall code using the CMS methodology when available Precedence shall be given to APCs transmitted from the health care provider.
MC074	APC Version	1/31/2007	Text	2	Version number of the grouper used.
MC075	Drug Code	1/31/2007	Text	11	Insurers and health care claims processor shall code according to NDC code.
MC076	Billing Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.

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Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC077	National Billing Provider ID	1/31/2007	Text	20	National Provider ID mandated for use under HIPAA.
MC078	Billing Provider Last Name	1/31/2007	Text	60	Full name of billing organization or last name of individual billing or Organization Name.
MC101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
MC102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
MC103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
MC104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.
MC105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
MC106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
MC899	Record Type	1/31/2007	Text	2	Value = MC

HAWAII ADMINISTRATIVE RULES

TITLE 12 DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

SUBTITLE 3

DISABILITY COMPENSATION DIVISION

CHAPTER 12

PREPAID HEALTH CARE

SUBCHAPTER 1

GENERAL

§12-12-1 Definitions. As used herein:

"Continuation of coverage in case of inability to earn wages" means that allocation of health care premium will be based on an employee's continuing salary, if this be the case, or the salary or wages that the employee received in the last fully completed month prior to the disability. Thus, the employer must continue the coverage by paying for the employer's share of the premium and the employee must contribute towards the premium to the same extent as prior to the disability.

"Covered employee" means an eligible employee who is provided health care coverage by an employer.

"Department" shall be as defined in section 393-3, HRS.

"Director" shall be as defined in section 393-3, HRS.

"Eligible employee" means an employee who has worked for an employer for twenty or more hours a week for four consecutive weeks, and earned 86.67 times the Hawaii minimum hourly wage.

"Employer" shall be as defined in section 393-3, HRS.

"Employment" shall be as defined in section 393-3, HRS, and shall include the period an employee is receiving benefits under chapters 386 or 392, HRS, for a period of not less than that prescribed in section 393-15, HRS. It shall also include services performed by an individual for wages or under any contract of hire irrespective of whether the common-law relationship of master and servant exists unless and until it is shown to the satisfaction of the director that:

(1) The individual has been and will continue to be free from control or direction over the performance of the service, both under the contract of hire and in fact;

(2) The service is either outside the usual course of the business for which the service is performed or that the service is performed outside of all the places of business of the enterprise for which the service is performed; and

(3) The individual is customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the contract of service.

"Four consecutive weeks" means any consecutive period of four weeks which an employee worked for an employer.

"Health care contract" means the entire approved plan of the health care contractor including its terms and conditions and benefit schedule.

"Premium" shall be as defined in section 393-3, HRS.

"Prepaid health care contractor" shall be as defined in section 393-3, HRS.

"Prepaid health care plan" shall be as defined in section 393-3, HRS. Prepaid health care plans which have the largest number of subscribers in the State are on file with the state department of labor and industrial relations, disability compensation division, and are available upon request.

"Regular employee" shall be as defined in section 393-3, HRS, but does not include dependents of an employee who are covered by a health care plan as an employee of the same employer.

"Regular wages" include an employee's disability income insurance provided for and paid entirely by the employer in excess of that required by any law.

"Seasonal employment" means employment by an employer defined in the second sentence of section 393-3(8), HRS, during its seasonal period or seasonal periods.

"Seasonal period or "seasonal periods" means the period or periods of seasonal activity of less than an aggregate of twenty-six calendar weeks in twelve consecutive calendar months in which the volume of employment by the employer in the pursuit, measured in terms of average weekly man hours per week, is at least fifty percent more than the average weekly man hours of employment by the employer in the twelve consecutive weeks in such twelve consecutive calendar months when the volume of employment by the employer is the lowest in such pursuit; provided that employment by an employer in seasonal pursuit engaged in the cultivating, harvesting, and processing of coffee and macadamia nuts and other crops or products constitutes seasonal employment during the employer's seasonal period or seasonal periods, provided further that employment during the seasonal period or seasonal periods by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapples constitutes seasonal employment.

"Self-insurer" means an employer as defined in section 393-3, HRS, who undertakes to provide the prescribed coverage and benefits directly to the employees without the intervention of a plan provided by a health care contractor or insurer subject to the insurance laws of the State.

"Statute" means chapter 393, HRS, entitled "Prepaid Health Care Act."

"Wages" shall be as defined in section 393-3, HRS.

"Week" means a period of seven consecutive days based on the established work week of each employer. [Eff: 5/7/81; am 9/16/85; am 1/13/92; am 8/19/96] (Auth: HRS §393-32) (Imp: HRS §§393-1, 393-3, 393-4, 393-5, 393-7, 393-11, 393-15)

§12-12-2 Determination of seasonal pursuit and seasonal period. (a) Employers believing themselves to be engaged in seasonal pursuits shall file a request for such determination with the director. The request shall contain data and information necessary to qualify the employer within the provisions as set forth in section 12-12-1 of this chapter and also as set forth in section 393-3(8), HRS, for the twelve months immediately preceding the date of the request for seasonal pursuit determination. The request shall also include similar data and information anticipated to be experienced in the current twelve month period. The request shall be signed by an authorized representative of the employer.

(b) The department shall review the request and information submitted and make determinations of seasonal pursuit and seasonal period or seasonal periods conforming to section 12-12-1. The decision of the department shall be certified in writing to the requesting employer and will remain in effect for the period specified in the decision.

(c) In order to establish the seasonal period or periods for each subsequent twelve month period

following initial determination by the department, the employer shall resubmit data and information specified in subsections (a) and (b) not later than one calendar month after the expiration date of the department's decision. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-3)

§12-12-3 Voluntary Coverage. An employer may voluntarily cover a person excluded under section 393-5, HRS, with a plan which will afford the person health care protection. Such voluntarily covered person shall not be entitled to the protection afforded by the statute or this chapter. [Eff: 5/7/81] (Auth: HRS § 393-32) (Imp: HRS §§393-2, 393-5)

§12-12-4 Monthly pay of regular employee. The monthly wages for the purposes of section 393-11, HRS, shall be 86.67 times the State's minimum wage rounded off to the next higher dollar. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-11)

§12-12-5 Employee responsibility. An employee exempt under the statute shall immediately file with the employer on a form provided by the department the reason for such exemption. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-15, 393-16, 393-17, 393-18, 393-21)

§12-12-6 Employee already disabled. Should an employer elect to change the health care plan or contractor while an employee is disabled, the employer shall provide a reasonable extension of benefits, which may be provided by the previous or succeeding

health care contractor. [Eff: 5/7/81; am 6/19/86] (Auth: HRS §393-32) (Imp: HRS §§393-12, 393-15)

§12-12-7 Health care advisory council. The council shall have discretion in determining which plans qualify under section 393-7, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-7)

§12-12-8 Director's rights and duties. The director's rights and duties shall be that prescribed by chapters 371 and 393, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-31, 393-32)

§§12-12-9 to 12-12-10 (Reserved)

SUBCHAPTER 2

PLANS

§12-12-11 Coverage. An employer may provide an approved individual or a group plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-11, 393-12, 393-13, 393-14, 393-15)

§12-12-12 More than one plan. An employer may elect to provide more than one approved plan from the same or different health care contractor. The employer shall not be liable for more than the cost of the least expensive plan should there be more than one plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-12)

§12-12-13 Classes of employees. An employer may provide different plans for different classes of employees. The employer shall not, however, exceed

the withholding requirements of section 393-13, HRS, should classes of employees be provided different plans. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-12, 393-13)

§12-12-14 Out-of-state employer-sponsored plans. Any employer-sponsored plan shall be submitted to the department by the authorized health care contractor in accordance with section 12-12-16. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-20)

§12-12-15 Collective bargaining agreement. Any prepaid health care plan included in a collective bargaining agreement:

(1) Is presumed to meet the requirements of the statute if the agreement is dated prior to June 3, 1978.

(2) Shall meet the requirement of the statute if the agreement is dated on or after June 3, 1978.

(3) Shall be filed by the employer with the department immediately upon approval of the parties whenever effected, modified, renegotiated, or extended. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-19)

§12-12-16 Submission of plans by health care contractors. (a) After the approval of a health plan by the Hawaii State Insurance Commissioner or a signed statement that the plan does not require approval, the health care contractor shall submit eight copies of the plan to the department for review.

Each plan shall have attached thereto the evidence of the insurance commissioner's approval or the statement that the plan does not require approval. Any plan submitted under section 393-7(b), HRS, which provides aggregate benefits that are more limited than those provided by plans qualifying under section 393-7(a), HRS, shall include certification that the employer has agreed to contribute at least one-half of the cost of the coverage of dependents under such plan.

(b) After written advice from the prepaid health care advisory council, the director shall notify the health care contractor of the proposed approval or disapproval of the plan. Any proposal to disapprove shall contain the reasons therefor.

(c) The health care contractor may apply for reconsideration in writing within fifteen days after receipt of the proposed disapproval. The request for reconsideration shall include a memorandum of the facts on the basis of which the contractor contends that the plan meets the requirements of section 393-7, HRS.

(d) The director shall notify the health care contractor of the final decision to approve or disapprove the plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§12-12-17 Employer's obligation. (a) Each employer shall inform an eligible employee of the entitlement afforded by this statute by providing the health care contractor's name, plan number, group

number, effective date of coverage, and employee's cost.

(b) The employer shall give each covered employee thirty days' notice should the employer elect to change the employer's plan or health care contractor.

(c) Any employer who withholds premium payments shall provide a covered employee who is incapacitated due to illness or injury, the following information in writing:

(1) Within two weeks of the disability date, the amount the employee is required to pay directly to the employer for forwarding to the health care contractor in order to continue coverage under section 393-15, HRS.

(2) At least two weeks prior to the date an employer will have completed the employer's obligation under section 393-15, HRS, the entire premium cost the employee is required to pay directly to the employer for forwarding to the health care contractor in order to continue coverage. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-11, 393-12, 393-13, 393-14, 393-15)

§12-12-18 supplemental coverage to required health care benefits. (a) When a health care contractor whose health care plan has been approved pursuant to section 393-7, HRS, subsequently provides supplemental benefits such as vision, drug, and dental coverage, these supplemental benefits shall then become a part of the employer's health care plan

whether or not initiated by employer or employees. When current or future employees must subscribe to such health care plan without having the option of excluding the supplemental benefits and its applicable cost, the cost of the required health care and supplemental benefits shall become the basis for allocation of premium specified in section 393-13, HRS.

(b) If an employee can choose not to accept the supplemental benefits, the employer may require an employee who elects the coverage to pay for the cost of the supplemental benefits. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-13, 393-15)

§§12-12-19 to 12-12-23 (Reserved)

SUBCHAPTER 3

HEALTH CARE CONTRACTOR REQUIREMENTS

§12-12-24 Self-insurer. Any self-insurer may qualify as a health care contractor upon furnishing satisfactory proof to the director of its solvency and financial ability to defray or reimburse in whole or in part the expenses of health care under an approved health care plan. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12)

§12-12-25 Health care contractor. Every health care contractor required to be licensed by the Hawaii State Insurance Commissioner shall be so licensed before submission of plans to the department. [Eff:

5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-7, 393-12)

§12-12-26 The health care insurance contract. (a) Every health care contract of insurers subject to the insurance laws of the State, including any amendment, endorsement, or rider to a contract, which provides for benefits under section 393-7, HRS shall be approved by the Hawaii State Insurance Commissioner prior to submission to the director under section 12-12-16.

(b) Nothing in the statute or this chapter is intended to amend, modify or change any policy form approval requirements prescribed in the State insurance laws. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12)

§12-12-27 The health care certificate. (a) Every covered employee shall be given written evidence of health care coverage by the employer, which has been provided by the health care contractor.

(b) The health care contractor shall permit continuation of coverage without any diminution of benefits or standards from the plan with which an employee was covered prior to disability during the period specified in section 393-15, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-14, 393-15)

§12-12-28 Cancellation of contract. (a) No health care contractor shall cancel a contract providing in whole or in part for health care benefits

required by the statute prior to the expiration date of the contract unless written notice of intention to cancel on a specified date and reason therefor has been filed with and served on the employer and the director at least ten days prior to the specified cancellation date.

(b) The ten days' advance notice requirement in subsection (a) need not be complied with when a new contractor is simultaneously substituted. In the event of substitution, the previous contractor shall immediately file with and serve on the employer and the director, notice that the contract was canceled, the specific date and the reason for cancellation.

(c) If a plan provides by its terms for an expiration date, acceptance of the plan by the director is notice thereof.

(d) The employer shall notify its covered employees of the cancellation of coverage for nonpayment of premium. The employees shall be given an option of individual coverage if premium payment is made within ten days directly to the contractor. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-12, 393-13)

§12-12-29 Refusal to insure. No health care contractor other than a self-insurer shall refuse to cover any employer-applicant except for the nonpayment of premiums. The health care contractor shall notify the director of all refusals to insure. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-7, 393-12, 393-13)

§12-12-30 Disqualification for benefits. Subject to the terms of the health care contract, a covered employee shall not be disqualified for benefits by a health care contractor except for the nonpayment of premium. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-11, 393-13)

§12-12-31 Agent. Each health care contractor shall provide the department with the name of an employee or officer of the contractor who is in direct charge of health care matters to whom all correspondence should be addressed. The person should be one who can be reasonably expected to expedite matters relating to the statute. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-3, 393-32)

§12-12-32 Contractors of union plans. Except as to section 12-12-16, all health care contractors, including self-insurers, providing benefits in accordance with a collective bargaining agreement shall comply with all the requirements of the statute and this chapter. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-2, 393-11, 393-12, 393-14, 393-15)

§12-12-33 Contractors of approved plans. Prepaid health care contractors with plans approved pursuant to section 393-7, HRS, are required to submit to the department of labor and industrial relations every December 31 the number of subscribers enrolled under each of their plans. If the subscriber count of one of their plans exceeds the count of their plan with the largest number of subscribers, the department must be notified within thirty days of

such change. [Eff: 8/19/96] (Auth: HRS §393-32) (Imp: HRS §393-7)

§§12-12-34 to 12-12-40 (Reserved)

SUBCHAPTER 4

BENEFITS AND CLAIMS PROCEDURE

§12-12-41 Withholding by employers. (a) An employer electing to withhold from covered employees may withhold the proportionate cost of the premium each pay period beginning in the month the employees' coverage becomes effective. In no event shall the employer withhold premiums less often than once monthly. An employer shall not withhold more than 1.5 percent of such employee's regular wages or one-half the cost of premium, whichever is less, during each calendar month.

(b) Withholdings by an employer shall be promptly paid to the health care contractor in accordance with the billing requirements of the contractor.

(c) Any employer fails to transmit payments to the health care contractor in accordance with the billing requirements of the contractor shall be penalized as provided under section 393-33, HRS.

(d) In the event an employer withholds but fails to obtain coverage from a health care contractor, the employer shall:

(1) Be liable for all health care expenses incurred by the employee.

(2) Refund the withheld premium to all employees.

(3) Be subject to penalties prescribed by section 393-33, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-13, 393-15, 393-24)

§12-12-42 Deductions greater than authorized. (a) In the event an employer withholds more than authorized by section 393-13, HRS, the employer shall:

(1) Refund such excess withholdings to the employee.

(2) Be subject to penalties prescribed by section 393-33, HRS.

(b) If an employee is no longer employed by the employer and cannot be located, the employer shall deposit such sum in the premium supplementation fund. The employer shall provide the director with the employee's full name, social security account number, last known address, the amount due, and any other information requested by the director. The director shall endeavor to locate such employee to return such deductions. If the employee cannot be located for a period of two years from the date of deposit, the director shall cause such moneys to become a part of the premium supplementation fund. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-13, 393-41)

§12-12-43 Notice and proof of claim. (a) Any covered employee claiming benefits or someone acting

in behalf of the employee shall furnish a written claim to the health care contractor pursuant to the health care contract.

(b) The claim shall include documents required by the health care contract. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-7)

§12-12-44 Denial of claim. (a) If an employee's claim is denied by a health care contractor in whole or in part because of nonpayment of premium, notice of denial in a form prescribed by the director shall be mailed promptly to the employee.

(b) If an employee desires a review of the denied claim, the employee shall file the prescribed notice of denial and a statement giving specific reasons for the request with the director. The request for review shall be filed within twenty days after the date of denial at the office of the department in the county in which the claimant resides or to any office of the department. The director shall forthwith notify the health care contractor of the claimant's request for review, enclosing a copy of the claimant's reasons therefor.

(c) The director, or an officer or employee designated by the director for that purpose, shall investigate the request and render a decision. The decision is final with right of appeal in accord with section 91-14, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§12-12-45 Controverted workers' compensation claims. In the event of a controverted workers'

compensation claim, the health care contractor shall pay or provide for the medical services in accordance with the health care contract and notify the department of such action. If workers' compensation liability is established, the health care contractor shall be reimbursed by the workers' compensation carrier such amounts authorized by chapter 386, HRS, and chapter 10 of title 12, administrative rules. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 392[sic]-32)

§12-12-46 Experience rating. If, after the end of a policy year, the employer receives an experience rating credit or a dividend from the health care contractor, the employee's share of the experience rating credit or dividend shall be refunded by the employer or applied to future premium payments of covered employees. "Employee's share" means the mathematical ratio of employer-employee contributions of the experience rating credit or dividend proportionately divided among all covered employees by months of service for the period of credit. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-13)

§§12-12-47 to 12-12-59 (Reserved)

SUBCHAPTER 5

REPORTS

§12-12-60 Health care contractors. (a) Health care contractors shall submit a monthly report, in a

form designated by the department, showing the following information:

(1) Name of newly enrolled or terminated employer;

(2) State department of labor and industrial relations account number as assigned by the unemployment insurance division;

(3) Plan number;

(4) Group number;

(5) Effective date of coverage; and

(6) Effective date and reason for cancellation.

(b) On April 15 of each year, health care contractors shall file an annual report for each employer and for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall contain the following information:

(1) Number of covered employees employed on the twelfth day of the month for each month of the year.

(2) Number of covered employees providing coverage for their dependents for each month of the year; and

(3) Amount returned to the employer due to experience rating credit or dividend during the year.

(c) On April 15 of each year, the following consolidated information shall be furnished by health

care contractors for all employers covered by such contractor:

(1) Number of claims filed by covered employees;

(2) Number of claims paid to covered employees; and

(3) Amount of claims paid to covered employees.

(d) If coverage is provided through an association of employers or to employers through a collectively bargained health and welfare type trust fund or similar arrangement, and it is not feasible to obtain information for each employer in the association or trust fund, the health care contractor may file a consolidated report in a form prescribed by the director. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-32)

§12-12-61 Employers. (a) On April 15 of each year, all employers providing coverage through a health care contractor shall file an annual report for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall provide the following information:

(1) Amount of total wages paid to covered employee;

(2) Amount of employer contributions paid in the year, and

(3) Amount of covered employee contributions paid in the year, if applicable.

(b) On April 15 of each year, employers who provide health care benefits directly to their employees shall file an annual report for each plan covering the most recently completed calendar year. This report shall be on a form prescribed by the director and shall provide the following information:

(1) Number of covered employees employed on the twelfth day of each month;

(2) Amount of total wages paid to covered employees;

(3) Amount of employer contributions paid in the year;

(4) Amount of covered employee contributions paid in the year, if applicable; and

(5) Amount returned to the employer due to experience rating credit or dividends, if applicable. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-32)

§12-12-62 Principal and secondary employer. (a) Any principal employer who is informed by an employee to be the secondary employer shall immediately notify the department of such change on the form provided by the department.

(b) Any secondary employer who is subsequently informed by an employee to be the principal employer shall immediately notify the department of such change on the form provided by the department. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-6, 393-16)

§12-12-63 Other employer reports. (a) Status report. Every employer for whom services are performed in employment shall file a report on a form prescribed by the director to determine liability for coverage within ten days after the status report form is mailed by the department. This report shall provide information such as: name of health care contractor, plan number, group number, effective date of plan, number of employees who claim exemption and reason thereof, and employer-employee premium cost for individual and dependents coverage. The employer's health care plan shall accompany this report, if the plan has not been approved by the director.

(b) Employer shall give the department thirty days written notice prior to change in health care plan or health care contractor.

(c) Employee notification to employer.

(1) Any employer whose employee claims exemption from the statute shall file a statement signed by the employee on a form provided by the department. The form shall be filed within ten days of employment or change in status.

(2) On December 31 of each year, each employer shall refile a statement signed by all employees who claim exemption from the statute on a form prescribed by the department. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-17, 393-21)

§12-12-64 Posting of notice of coverage. Each employer shall post and maintain in a conspicuous place or places in and about the place of business type-written or printed notices stating that the employer has obtained health care coverage required by law, in the form as may be prescribed by the director. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §§393-7, 393-32)

§§12-12-65 to 12-12-69 (Reserved)

SUBCHAPTER 6

PREMIUM SUPPLEMENTATION

§12-12-70 Entitlement to premium supplementation. (a) "Less than eight employees" shall mean the total number of employees who are entitled to and covered as of the twelfth day of each calendar month. An employer who provides coverage to eight or more employees entitled to coverage in a month shall not qualify for premium supplementation for that month.

(b) An employer must be in business for profit to qualify for premium supplementation.

(c) Premium supplementation for the employer's taxable year shall be awarded for those months in that taxable year in which the employer satisfies the requirements of section 393-45, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-45)

§12-12-71 Claim for premium supplementation. (a) A claim for premium supplementation for an employer's taxable year shall be filed with the department within two years after the end of such year. Any claim filed after two years shall not be honored.

(b) The premium supplementation claim shall be filed on a form designated by the department. The claim shall be accompanied by the employer's federal and state tax returns for the years claimed and all books of accounts as may be requested by the department.

(c) Premium supplementation shall be paid rounded off to the nearest dollar. A claim for less that [sic] $1 shall not be processed or paid. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-47)

§12-12-72 Reduction of premium supplementation. (a) The amount of premium supplementation due shall be reduced by the experience rating credit or dividend received by the employer from a health care contractor.

(b) If an experience rating credit or dividend is received after the premium supplementation is paid to the employer, the department shall reduce any premium supplementation awarded within the next two years by the employer's share of the amount of such experience rating credit or dividend. [Eff 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-45)

§12-12-73 Coverage by the fund. (a) Notwithstanding section 12-12-41(d), the premium supplementation fund shall provide benefits to an eligible employee whose employer has failed to provide coverage in the following manner:

(1) The eligible employee shall be deemed to have selected the most prevalent reimbursement plan if the services were obtained from a health care provider normally paid by such plan.

(2) The eligible employee shall be deemed to have selected the most prevalent fee for service plan if services were obtained from a fee for services health care provider.

(b) The premium supplementation fund shall reimburse the eligible employee for payment of fees based on subsection (a)(1) or (2) less the premium the employee would have paid for such coverage. A claim for reimbursement shall be filed on a form provided by the director within two years after such services are provided, and shall contain a certification by the eligible employee that the employer has refused a written request to provide the required benefits to the eligible employee. An employer shall be deemed to have refused to provide such benefits where the employer fails to contact such eligible employee within thirty calendar days after such eligible employee makes a written request to the employer for such benefits at the employer's place of business.

(c) Any employee who is eligible for or received benefits under other laws shall not be entitled to benefits under this section.

(d) The health care contractor with the most prevailing plan selected in the category of subsection (a)(1) or (2) shall assist the department, upon request, in arriving at the proper reimbursement to the eligible employee. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-48)

§§12-12-74 to 12-12-75 (Reserved)

SUBCHAPTER 7

PENALTIES

§12-12-76 Penalties. Penalties under section 393-33, HRS, shall be assessed by the director, or a designated representative, after hearings held in accordance with chapter 91, HRS. [Eff: 5/7/81] (Auth: HRS §393-32) (Imp: HRS §393-33)

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF VERMONT

Liberty Mutual Insurance Company, Plaintiff v. Stephen W. Kimbell, in his capacity as the Vermont Commissioner of Banking, Insurance, Securities and Health Care Administration, Defendant.	)	Docket No. 2:11-cv-00204-wks

AFFIDAVIT OF DIAN KAHN

Dian Kahn, having been sworn, states the following under oath:

1. I am an employee of the Vermont Department of Financial Regulation ("the Department"). Until the spring of 2012, the Department was known as the Department of Banking, Insurance, Securities and Health Care Administration.

2. I am the Director of Analysis & Data Management for the Division of Health Care Administration for the Department. In this capacity, I administer the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). I have served in this position since at least 2000. I have been employed by the Department for approximately 17 years.

3. Blue Cross Blue Shield of Massachusetts (BCBSMA) reports data and membership information to the VHCURES.

4. I have reviewed the VHCURES data from Calendar Year 2010, the most recently completed data set. Section 5 and 6 (below) refer to Calendar Year 2010.

5. BCBSMA reported a total of 5,701 average members (members per month). BCBSMA reported a total of 2,511 average members for self-funded plans for which it provides primarily or exclusively administrative services as the third-party administrator, including plans for which BCBSMA provided stop-loss insurance in addition to providing administrative services. Most, if not all, of those plans are assumed to be ERISA plans. Liberty Mutual's plan is among those that BCBSMA provides administrative services for.

6. BCBSMA reported on a total of 7,605 unique members (including members who are only briefly or partially enrolled in a plan that BCBSMA reports on). BCBSMA reported on a total of 3,667 unique members for self-funded for which it provides primarily or exclusively administrative services as the TPA. Most, if not all, of those plans are assumed to be ERISA plans.

Further affiant sayeth naught.

/s/ Dian Kahn
Dian Kahn

Subscribed and sworn to before me on this 13th day of August, 2012.

/s/ Diane L. Lewis
Notary Public

My Commission Expires: 2/10/15

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Colorado	*Program* Colorado All Payer Claims Database *Agency* Center for Improving Value in Health Care (CIVHC)	*Year Statute Enacted* 2010 *Statute* Colo Rev Stat § 25 5-1-204 (2010) *Rules & Regulations* 10 C C R 2505-5	Eligibility data files, medical and pharmacy claims data files Required information includes Name, extraction date, social security number, contract number; gender, date of birth, address, medical coverage, race, ethnicity, service provider specialty, etc	Colorado generally collects data from public and private health care payers "Private health care payer" is defined as an "insurance carrier covering an aggregate of 1,000 enrolled lives " 10 C C R 2505-5 at 1 200 1 The term "insurance carrier" is expressly limited to entities "subject to the insurance laws and regulations of Colorado " C R S § 10-16-102(8) As currently set up, Colorado's database "won't have information" on employees who receive benefits from "self-insured" companies' plans http://civhc org/getmedia/8c3f2d6c-4cc0-4675-8c21-88ca1a60bcaf/APCD-FAQs_4 2012 pdf aspx (p 6)

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Kansas	*Program* Data Analytic Interface (DAI) *Agency* Kansas Health Data Consortium/ Division of Health Care Finance (DHCF) (with support from the Kansas Insurance Department)	*Year Statute Enacted* 2006 *Statute* Kan. Stat Ann § 65-6801, et seq (2006) *Rules & Regulations* N/A	Eligibility, medical and pharmacy claims	The statute generally provides for data submission by medical care facilities, health care providers, home health agencies, and third party payors K.S.A. § 65-6801 states that "self-funded employee health plans, shall file health care data with the Kansas health policy authority as prescribed by the authority." However, thus far, the database appears to only include government-provided health care data. See http://www.kdheks.gov/hcf/medicaid_reports/Health_Care_Market_Reports.html
Louisiana	*Organization* Louisiana Health Care Quality Forum	*Statute* N/A *Rules & Regulations*	Eligibility, medical and pharmacy claims	This is a voluntary program which allows for submission of data by providers, payers, purchasers and consumers

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Maine	*Program* Maine Health Care Claims Database *Agency* Maine Health Data Organization	*Year Statute Enacted* 2001 *Statute* Me Rev Stat Ann Tit 22 §§ 8701-8713 (2009) *Rules & Regulations* Code Me R § 90-590, Chs 120 and 243 (2011)	Eligibility, dental, medical, and pharmacy claims, health care service provider files *Information collected includes* Type of product, type of contract, subscriber/member number, social security number, name; date of birth, gender, address, diagnosis code; procedure code, revenue code, service date, service provider, billing provider, plan payments, member payment, date paid, etc	Data is generally collected from health care providers and payors Payors includes health insurer carriers, third party administrators, Medicare health plan sponsors, and pharmacy benefits manager However, "[a]n employer exempted from the applicability of 24-A M R.S.A., chapter 56-A under the federal Employee Retirement Income Security Act of 1974 [ERISA] is not considered a carrier " Code Me R. § 90-590, Ch 243 at Sec 1 C Providers and payors are generally required to submit data if they cover or treat more than 49 Maine residents for which claims are being paid in any one month

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Maryland	*Program* Maryland Health Care Commission Medical Care Data Base *Agency* Maryland Health Care Commission (MHCC)	*Year Statute Enacted* 2000 *Statute* Md Code Ann , Health § 19-132, et seq , (2011) *Rules & Regulations* Md Regs Code Tit 10 § 25 06 (2011)	Eligibility, medical and pharmacy claims *Information collected includes* Professional Services Data Report, Pharmacy Data Report; Provider Director Report, Institutional Services Data Report, Medical and Pharmacy Eligibility Report, Patient identifier, date of birth, gender, zip code, claim paid date, diagnosis code, coverage type, claim-related condition, service date; billed charge, allowed amount, reimbursement amount, deductible, date of enrollment, co-payment, plan liability	The statute generally applies to insurers, HMOs, PBMS, TPAs that manage health benefit plans on behalf of a self-insured employer, third party administrators of self-funded plans, Medicaid and Medicare "[T]he Executive Director shall designate the payers that are required to submit data reports based on the payer's premium volume", however, this is "based on [premium] information reported by the payer to the Maryland Health Care Commission." COMAR 10 25 06 01 and 03(A)

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Massachusetts	*Program* All-Payer Claims Database *Agency* Massachusetts DHHS, Division of Health Care Finance and Policy	*Year Statute Enacted* 2010 *Statute* Mass Gen. Laws Ch. 118G §§ 6-6A (2010) *Rules & Regulations* Mass Regs Code Tit 114 5, §§ 21-22	Eligibility, dental, medical, and pharmacy claims; collection of provider and production files *Information collected includes* Subscriber and member identifiers, race, ethnicity, language information, plan type, benefit codes, enrollment start and end dates; behavioral and mental health indicators, substance abuse indicators, chemical dependency indicators, prescription drug benefit indicators	Massachusetts law generally requires reporting by public or private health payors, including insurance carriers, HMOs, nonprofit hospitals, and medical service corporations However, the definition of "private health care payor" specifically includes "self-insured plan[s]" only "to the extent allowable under federal law governing health care provided by employers to employees " Mass Gen Laws Ch 118G § 1 In addition, entities that cover less than 1,000 State residents are generally not required to report
Minnesota	*Program* Minnesota Health Care Claims Reporting System *Agency* Minnesota Department of Health	*Year Statute Enacted* 2009 *Statute* Minn Stat § 62U 04 (2010) *Rules & Regulations* Minn R 4653 0100, et seq.	Eligibility, medical and pharmacy claims Required information includes· Insurance type, gender, date of birth, address, medical coverage, admitting diagnosis, procedure code, paid amount, etc	Minnesota law generally defines "data submitter" to mean "a health plan company or third-party administrator that paid a total of at least $3,000,000 in health care claims for covered individuals during the previous calendar year," and defines third-party administrator to include TPAs that administer self-insured plans *See* Minn. R 4653 0100 at subparts 8, 18

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
New Hampshire	*Program* New Hampshire Comprehensive Health Care Information System *Agencies* Partnership between New Hampshire Insurance Department and New Hampshire Department of Health and Human Services	*Year Statute Enacted* 2001 *Statute* N H Rev Stat Ann § 420-G 11-a (2005) *Rules & Regulations* N H Code Admin R Ann Ins 400-A 15 and 420-G 14 (2009)	Dental, eligibility, medical and pharmacy claims	Reporting rules generally apply to entities subject to insurance laws and rules of the State, including HMOs, non-profit health services corporations, TPAs or other entities arranging for or providing health coverage Data must be submitted for all State residents and for all members who receive services under a policy issued in the State The New Hampshire regulation provides that "third party administrator[s] shall be responsible for submitting claims data on self-insured plans that [they] administer " Reg 4004 01(f) Third party payors that write less than $25,000 in insurance premiums in the State on an annual basis, and TPAs that administer health insurance plans covering fewer than 200 New Hampshire lives, are not required to comply with reporting requirements

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
New York	*Program*: Name to be determined *Agency*: New York State Department of Health	*Year Statute Enacted*: 2001 *Statute*: N.Y. Pub. Health § 2816 *Rules & Regulations*:	Claims data related to inpatient, outpatient, emergency department, pharmacy, eligibility information, and other health care services.	Not specified; regulations forthcoming.
Oregon	*Program*: Oregon All Payer Claims *Agency*: Office for Oregon Health Policy and Research	*Year Statute Enacted*: 2009 *Statute*: Or. Rev. Stat. §§ 442.446; 442.464; 442.993 (2009) *Rules & Regulations*: Or. Admin. R. 409-025 (2010)	Medical claims, eligibility, medical provider, pharmacy claims, and control totals. *Required information includes*: Enrollment data; paid claims; denied claims; payer name; claim ID; member ID; claim status; diagnosis; allowed amount; payment; co-payment; deductible; reports, schedules, statistics, or other data relating to health care costs, prices, quality, utilization; and, data related to race, ethnicity, and primary language.	The statute generally defines "reporting entity" to mean insurers, health care service contractors, third party administrators, pharmacy benefit managers, and coordinated care organizations. *See* O.R.S. 442.464. For insurance carriers and TPAs, this includes health care claims data for self-insured plans. All insurance carriers and TPAs with calculated mean total lives of 5,000 or higher are mandatory reporters.

State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Rhode Island	*Program*: Rhode Island All Payer Database *Agency*: Rhode Island Department of Health	*Year Statute Enacted*: 1998 R.I. Gen. Laws § 23-17.17 *Rules & Regulations*:	Data submission requirements will be included in forthcoming regulations. May include health insurance claims and enrollment information used by insurers, information related to hospital finance, and any other information related to health care costs, prices, quality, utilization, or resources as required by the director.	The statute will generally require reporting by "insurers, health care providers, health care facilities and governmental agencies" to the extent "determined by the director to be necessary to carry out the purposes of this chapter." § 23-17.17-10(a). The term "insurer" is defined to mean "any entity subject to the insurance laws and regulations of this state." § 23-17.17-2(f).
Tennessee	*Program*: Tennessee All Payer Claims Database *Agency*: Department of Finance and Administration, Division of Health Planning	*Year Statute Enacted*: 2009 *Statute*: Tenn. Code. Ann. § 56-2-125 (2011) *Rules & Regulations*: Tenn. Comp. R. & Regs. §§ 0780-01-79-.01 through §§ 0780-01-79-.07	Member eligibility, medical claims, and pharmacy claims files. *Required information includes*: Type of insurance; coverage type; gender; date of birth; address; payer claim control number; paid date; admission date; discharge hour; discharge status; service provider number; admitting diagnosis; quantity of service provided; copay amount; drug code; etc.	Tennessee law generally requires reporting by all group health plans and health insurance issuers. *See* Tenn. Code Ann. § 56-2-125(f)(1)(A). "Group health plans" are defined as "employee welfare benefit plan[s]" identified in Section 3(1) of ERISA, but the definition excludes "any plan that is offered through a health insurance issuer." Tenn. Code Ann. § 56-2-125(a)(4). Health insurance issuers that paid less than $5 million for covered residents of Tennessee during the previous calendar year are not required to submit health care claims data set.

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
Utah	*Program*: Utah All Payer Claims Database *Agency*: Utah Department of Office of Health Care Statistics	*Year Statute Enacted*: 2007 *Statute*: Utah Code Ann. § 26-33a-104, et. seq. (2011) *Rules & Regulations*:	Enrollment, medical claims, and pharmacy data where Utah is the patient's primary residence and the same for services provided out of state to Utah residents. *Required information includes*: Transaction code; member ID; social security number; address; date of birth; race; ethnicity; diagnosis; etc.	Utah law generally defines "data supplier" to mean any health care facility, health care provider, third-party payor, health maintenance organization, government department, or self-funded employer. Utah Code Ann. § 26-33a-102(3). An entity that covers more than 200 individual Utah residents is required to submit data.
Washington	*Program*: Washington All Payer Claims Database (a non-state administered system) *Organization*: Puget Sound Health Alliance	*Statute*: N/A *Rules & Regulations*:	Eligibility, medical and pharmacy claims.	A voluntary program that includes various health purchasers and other entities.

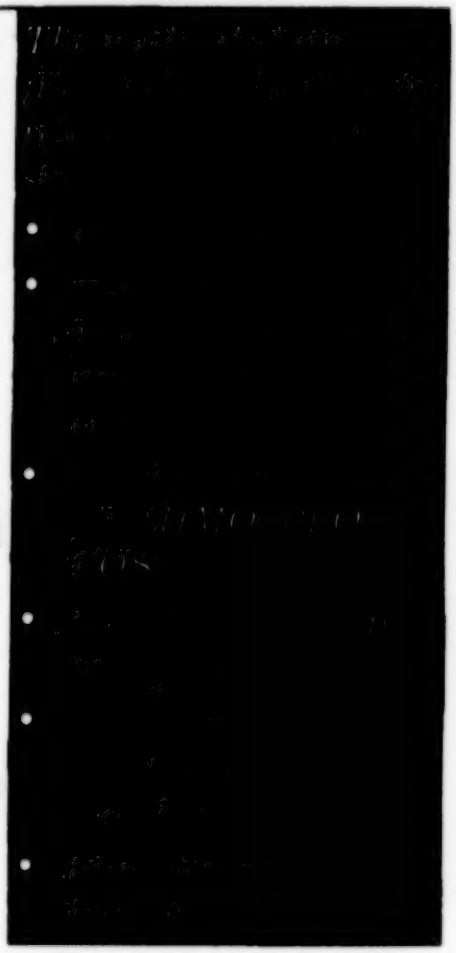
State Health Reporting Laws

Summary Table

STATE	NAME OF PROGRAM/ RESPONSIBLE STATE AGENCY	PRIMARY STATUTE/ RULES & REGULATIONS	INFORMATION GENERALLY TO BE REPORTED	ENTITIES GENERALLY COVERED BY STATUTE
West Virginia	*Program*: West Virginia Health Care Authority Database *Agency*: West Virginia Health Care Authority	*Year Statute Enacted*: 2011 *Statute*: W. Va. Code § 33-4A-1, et. seq., (2011) *Rules & Regulations*:	Enrollment, eligibility, medical claims data, and pharmacy claims data.	The statute generally provides for reporting by any entity that pays or administers the payment of health insurance claims or medical claims under workers' compensation insurance, including "any third-party administrator . . . that administers a fully-funded or self-funded plan." W. Va. Code § 33-4A-1(e). Health care payers that paid or administered the payment of health insurance claims on fewer than 500 covered lives in the previous calendar year are exempt.
Wisconsin	*Program*: The WHIO Health Analytics Exchange (a non-state administered system) *Organization*: Wisconsin Health Information Organization (WHIO), a private nonprofit organization.	*Year Statute Enacted*: 2009 *Statute*: Wis. Stat. § 153.80, et. seq., (2019) [sic] *Rules & Regulations*:	Eligibility, medical and pharmacy claims.	A voluntary program whose members include various health insurance companies and other entities.

What are All-Payer Claims Databases?

In the context of the current national dialog about health care and reform, states are trying to better understand and control healthcare costs and utilization. Over the past five years, at least twelve (12) states have enacted legislation and/or started to collect healthcare claims data from commercial and public payers in an effort to establish all-payer claims databases (APCDs). These data are being analyzed to understand patterns and trends of healthcare use and costs.



These databases hold the potential for a much deeper understanding of quality and cost of care across populations. The source of the data is from healthcare billing systems that process claims for private and public payers. In addition, some states are developing methods to capture data for uninsured individuals.

While the contents of individual states' APCDs vary, they typically include data from member eligibility files, provider files, medical and pharmacy claims files, and in a few states, dental claims files. The medical claims files include healthcare related data elements such as diagnosis codes, types of care received (procedure and pharmacy codes), insurance product type (HMO, PPO, POS), facility type (hospital, office, clinic), "cost" amounts (charge, paid, member liabilities), and provider information.

APCDs are being constructed and used for various research and policy purposes, from public health to health services and public policy research, consumer tools, employer coalition reporting, and payer and provider negotiation. For example, in New Hampshire, claims data have been used to better understand the distribution of health insurance coverage. Massachusetts has used the data to develop a public portal for pricing and quality information. Vermont has conducted a tri-state study of use of care in the Northern New England area. Minnesota will be using APCD data for development of provider peer grouping analysis (a method to compare providers based on a combination of cost and quality measures)[i]. Beyond public policy efforts, APCDs are being used by employer coalitions, insurers, providers, think tanks, and consumer groups. More examples can be found in the APCD Fact Sheet (available at www.apcdcouncil.org)[ii]

Why data collection standardization?

While APCDs represent a great opportunity to advance the understanding of cost, utilization, and quality of healthcare, currently each state is collecting different data by different methods and with different definitions. This non-uniform approach to developing APCDs is limiting the ability to share analysis and applications across states, and is raising costs for payers submitting data to the states (especially those payers that are operating in multiple states).

Standardization of data collection would ensure that states collecting the same data would do so in the same manner. A standardized data file submission would use an identical file structure (i.e., data element positioning and field lengths) in each state's database, but would not require that every state collect data for each element. Also, because individual states will likely want to have some data elements that are unique, processes for modifying the standard file structure to include additional data elements will need to be developed.

There has been some effort in the New England area to harmonize data collection efforts among Maine, New Hampshire, and Vermont. The initial rationale for this work towards standardization was to support regional-level analysis for these states that share borders and have cross-state use of the healthcare system. The harmonization of the data supported a

tri-state comparative study of healthcare cost and utilization across these three states, for example[iii]. As another example of the utility of standardization, the similarity of the data elements in Maine and New Hampshire allowed Maine to adopt the New Hampshire HealthCost[iv] methodology to efficiently create a similar web application[v] for Maine's APCD data.

What does it take for payers to provide this data?

As APCDs are required in more states, the cost to payers will become significant. APCD stakeholders have a common interest in reducing administrative costs associated with health care, and working together to establish an efficient, cost-effective APCD process should be a common goal. Because payers each use unique systems to administer their business, the challenges for payers to provide the required data vary. In general, a state will be more successful in collecting data elements if payers need those data elements to conduct their core business (versus situations in which states request data elements in the APCD that are not normally collected by insurance carriers). For example, payers have data needed to pay a provider, because claim payment is a core business function. Payers are less likely to know whether a provider has electronic medical records, for example, because that is unrelated to a core business function. Stakeholders should consider the relative costs and benefits of including a particular data

element in the APCD if payers do not ordinarily collect it. This can be done through engagement of industry partners to determine the business case for collection of additional data elements. Where feasible, the data elements and value sets proposed should be derived from existing and accepted data standards. For example, for the collection of patient language, International Organization for Standardization has several existing value code sets (e.g. ISO 639-2, 639-3).

Payers need a minimum of nine months to make systems changes and program the initial APCD data sets, and they recommend limiting changes to once a year, with six months advance notice. This allows payers to allocate programming resources and funding and creates a predictable schedule for all parties. Having standardized data elements, a predictable schedule with sufficient lead time for changes, and an ongoing collaborative process with all stakeholders on which data elements are required will support an efficient, cost effective APCD.

How can standardization of APCD data collection be achieved?

Existing Data Standards Maintenance Organizations (DSMOs), such as ANSI X12N (www.x12.org) and the National Council for Prescription Drug Programs (NCPDP, www.ncpdp.org), are responsible for developing and maintaining industry standards for insurance claims and eligibility files. These organizations have

formal processes for maintaining standards, including input, discussion, and publication. Many of the states that have developed APCDs reference the X12 standards in eligibility files and medical claims, and NCPDP standards in pharmacy claim files.

The Agency for Healthcare Research and Quality (AHRQ) has supported the APCD Council (www.apcdcouncil.org) to draft a core set of data elements for both the eligibility and medical files of APCD data submissions[vi]. The temporary core set of data elements is intended to foster harmonized data collection across states, and to start the process of developing a formal national standard for state-based APCD data submission. The process for creating the temporary core set of data elements for APCD includes three stages:

(1) Develop and vet a draft of a common core set of APCD data elements based on an inventory of the data elements for six APCDs from the states of Maine, New Hampshire, Vermont, Minnesota, Tennessee, and Massachusetts. (A draft of the state-by-state comparison and the details of the APCD elements can be found at: http://apcdcouncil.org/econometricaagency-healthcare-research-and-quality-ahrq)

(2) Vet draft recommendations with a larger group of other relevant national and local organizations in order to build consensus to harmonize data collection

(3) Engage the relevant DSMOs in the standards development

Similar pharmacy data standards work is being coordinated by the National Council for Prescription Drug Programs (NCPDP). Future work will need to occur with dental claims and provider index files.

The United States Health Information Knowledgebase (USHIK; http://ushik.ahrq.gov) project has inventoried the data collected by several states, and has established a metadata registry that enables comparisons of data element collection standards across data organizations. This is especially useful for states who are considering developing an APCD, or states who wish to change their data collection rules.

Summary

Over a dozen states across the country have enacted legislation and/or started to collect healthcare claims data from commercial and public payers in an effort to establish all-payer claims databases (APCDs). The state APCD efforts have begun as a way to better understand healthcare costs, quality, and utilization. While APCDs represent a significant opportunity to advance the understanding of these issues, currently most states are collecting different data by different methods and with different definitions. This non-uniform approach will limit the ability to share analysis across states and has negative cost implications for the payers who are submitting the data.

Standardization of state APCD data collection would address these issues. With assistance from existing DSMOs (i.e., ANSI X12N, NCPDP, in collaboration with the Agency for Healthcare Research and Quality (AHRQ), the APCD Council (www.apcdcouncil.org) has begun efforts to draft a temporary core set of data elements for both eligibility and medical files of APCD data submissions. Though this draft is the first step in a process of standards development, it begins the process of developing a formal national standard for state-based APCD data submission. Working with NCPDP and ANSI X12, final data collections standards will be developed for state adoption.

There is a clear goal to ensure that standards are available in 2011 for adoption by states as they develop new legislation or modify existing legislation.

Fact sheet prepared by the All-Payer Claims Database (APCD) Council in collaboration with the National Association of Health Data Organizations (NAHDO). Lead authors, Ms. Amy Costello, Project Director with the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire and Ms. Mary Taylor, Head of Regulatory Compliance with Aetna.

For More Information on APCD's visit the following sites:

All-Payer Claims Database Council: http://www.apcdcouncil.org/

National Association of Health Data Organizations: http://www.nando.org/

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[i] Minnesota Department of Health, *Provider Peer Grouping*, http://www.health.state.mn.us/healthreform/peer/index.html

[ii] APCD Council, *APCD Fact Sheet 2010*, http://www.apcdcouncil.org/sites/apcdcouncil.org/files/APCD%20Fact%20Sheet_FINAL_1.pdf

[iii] Onpoint Health Data, *Tri-State Variation in Health Services Utilization & Expenditures in Northern New England*. http://www. bishca.state.vt.us/sites/default/files/Act49-Tri-State-Commercial-Variation.pdf

[iv] NH Healthcost, http://www.nhhealthcost.org

[v] Maine HealthCost, *Procedure Payments for the Insured*, http://www.healthweb.maine.gov/claims/healthcost/procedure_pricing_insured.aspx

[vi] Dental files and provider index files are currently not being addressed in the first phase.

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